Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 per MD g896 10/28/09 TT State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) Marie Grochowski 2. Date of Death Month 2009 10 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death lizabeth enter IMOV 8. Date of Birth March Day, Year) 920 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country)
 MD 1 □ M 2 🛛 F 89 Months Days Hours Min. 218-01-3680 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore City 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Dillon Street 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Zellinger Lena Rodenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Grochowski, Son 10205 S. Greentree Court, Olathe, Kansas 66061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/16/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skarda Funeral Home 2829 Hudson Street, Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the de lih. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumom rl ClXV Due to (or as a consequence of): Saque Ittally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

burial-tran The law requires that the death certificate be exect P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, certificate this After death.

Physician

Examiner

Funeral

Director

28a-f show

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Important: if ite
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Physician

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Certification:

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(Check only one)

29a, Certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

completely filled in by the funeral director, Hospital or Attending s after death. within 24 hours a the

> State Registrar

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1)55391

30. Name and address of person who competed cause of death (Item 23a) (Type, Print) MO

,20 Bonson Hvenue 32. Registrar's Signature

phioinu.

Baltimore, Maryland

31. Date filed (Month, Day, Year) OCT 28 2009 Denus B. par

State of Maryland / Department of Health and Mental Hygien 9 1 9 34502 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 0200V Day Physician ame October 4, 2009 9:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Sandtown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□ F Days Hours Director 71 216-26-7754 Mar 15. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c, City, Town or Location 10h Counts or 28s-f show treumatic event, the Medical Examiner must be notified at 1.☐ Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 917 Carrollton Avenue 21217 USA or items 23a Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No U If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: black 3 □ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as important: if Item 27 is eny injury or other treuonce. Future Care Sandtown 1000 N. Gilmore Street Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signatu of Funeral Spruce Licensee ROnal d S. Wane 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ed by the attending physicien and detached for use es the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death heck only one Other: Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Sing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending after death.
I Director: Aft investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours all To the Funerel D Certifying Trysician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/21/200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mortin, Day, Year) Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Reg. No. 2 0 0 9 34503 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Ye ar 1:00 PM William Edward Griggs actober 500 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Tina Baltimore Citi Homere 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-12-1917 **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Min Director 219-01-9272 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanteur, but be notified at Director 1 XYes 2 □ No Baltimore \mathbf{M} n/a 10e. Street and Number 10g. Citizen of What Country? 4513 W. Forest Park Avenue 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ¹¾☐Yes 2 ☐ No if Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: African-American þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than ' any injury or other traumatic event, the Maginde. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Baltimore CityPublic Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Thomas Griges Mary Peck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4513 W. Forest Park Avenue, Balto. MD 21207 Angela M. Griggs/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
ACCUTUS Nem. Fack Date 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 11-2-09 Arbutus, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wile Funeral Home P.A. of Palto. Co. 9200 Liberty Road, Randallstown, MD 21133 234 Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death : Acute Myacarpine Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Meumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No this certificate has been signed by the al director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an performe 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

O6+1

State Registrar

31. Date filed (Month, Day, Year)

30. Name and addr

Ocmush OC 32 Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

JIMAI T

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10/26/09

inai Hospital of Boltiman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 9 0 9 34504 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 25, 2009 1:40a M June Inez Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗹 F Months Days Hours <u>217–28–1430</u> Feb. 18, 1931 Virginia Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 E. Aztec Street Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 200 No þ Specify Specify: white 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary funeral 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holt Bledsoe Ruby Fraley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen, Maryland 21001 Larry A. Green (son) 127 West Inca Street, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfield Union Cemetery 10/30/09 Fairfield, PA 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Tarring-Cargo Funeral Home
Aberdeen, Maryland 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL VASCULAR ACCIDENT ACUTE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner Divo to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Medical Certification: To

/Medical 30036563 Examiner 68760, o Records, Vital o Division

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Funeral

Director

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene, 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Evanthar must be notified at

Department of Health a Important: If item 27 is any Injury or other trau

Physician

burial-trai

Pages 1

Maryland 21215-0036

Baltimore,

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To the Hospital or Attending within 24 hours ter death. within 24 hours To the Funeral completely

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								24a. Was an autopsy performed? 1 □Yes 2 ₩No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case referrexaminer?	ed to medical				26.	Place of Dea	th (0	Check only one)	
1 ☐ Yes 21 ☑	No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home					ome	e 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 2 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	28c.	Injury at Work? 1 □Yes	2 No	280	d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined						281	f. Location (Street and City or Town, State)	l Number or Rural Route Number,
20a Cortifier	1 Cortifuing Dh	welclan: To the best of my kno	outledge death secure	ad at t	ha time a	data and alas			

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier lud Nowaleowsk

29c. License number DO P096 29d. Date signed (Month, Day, Year) OCTOBER 26, 2009

BEZAR, MD 21014

State Registrar

31. Date filed (Month, Day, Year) OCT 28 2009

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 A 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Of 6635M OFFMANN NIEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tate House Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7/15/48 Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1 M 2 □ F Days Hours Min Director 217-52-3537 Usual Residence of Decedent 61 Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show is marked other than "natural", or Items 23a or 28a-f shot aumatic event, the Nedbal Evander in ust be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with by Funeral <u>321 Bar Harbor Road</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Post Office <u>Postal Clerk</u> 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hilmportant: If item 27 is marked othany Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Murray G. Hoffmann Viola Wonsonich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Christine M. Teal <u>Bar Harbor Road</u> Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/30/09 Loudon Park Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licers e 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Maryland 4 0 3620 Wilkens Ave. 23a. Part 1. Enter the disease, or construction of the shock, or heart failure. List on the shock of the shoc cations that caused the ne cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** llars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s 24a. Was an autopsy his certificate h I director, page 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No After this funeral din Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other のにじ 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

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DHMH 17 Rev 1/2001

State

Registrar

29c. License number

3

29d. Date signed (Month, Day, Year)

HWAY ANNAPOLES MDZIED

and manner stated

32. Registrar's

ed cause of death (Item 23a) (Type, Print)

and address of person what

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Hook Nancy Lee 25 ctober 2009 1:00 AM 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Hospital Baltimore Baltimore 0 8. Date of Birth (Month, Day Year) 5. Social Security Number If Under 1 Year _ If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours Min. Country 215.34.0495 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Nes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21239 1223 Silverthorn Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ No Specify 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Elizabeth Seymour Scharmann Monroe Albert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Hook/Son 7892 Harold Rd. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 10.28.09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD 21286 du 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final ancreati. disease or condition resulting in death) Due to (or as a consequence of): 3 weeks Sequentially list conditions any leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month 5 Other (specify) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 25. Was case referred to medical 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medicai Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show mast be notified at

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or items 23a

"natural"

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permit. Pages 1 and 2::
Department of Health a Important: If item 27 is any Injury or other trauonce.

Director

Funeral

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Completed

72 hours after death with the Maryland

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore, **才00**上

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Be

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 mon 9 Unknown þ Completed

27. Manner of Death

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26. Place of Dea	th (Check only one)	
ner: 4 🗌 Nursing H	lome 5 ☐ Residence 6 ☐	Other (Specify)
ryat k?]Yes 2 ∐No	28d. Describe how injury o	
	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,

29b. Signature and	title of certifier	, M.D		29c. License number		29d. Date signed (Month, Day, Year) October 25, 200	7
29a. Certifier (Check only one)	1X Certifying Phys 2☐ Medical Examin	Iclan: To the best of my known of the basis of examination and manner stated.	owledge, death occurration and/or investigat	red at the time, date a tion, in my opinion, de	and place, and due to the ath occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)	_
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fact fy)	tory, office		(Street and Number or Rural Route Number, own, State)	
1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Day, Year)	Injury M	Work?		s now analy occurred	

28c. Inju Wo

28b. Time of

State

1 eamrat 31. Date filed (Month, Day, Year) Registrar

Adhanom 32. Rev

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

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24 hours a

within 24 hou To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month LOBER Hughes, Jr. John Carl 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Maryland Fimore General 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Country) Days Hours Min. 1**⊠**M 2□ F 65 219.40.8247 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 12 Yes 2 □ No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21214 4503 Harford Rd. Apt. 3 A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? □Yes 2 No Specify: white 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fast Food Elementary/Secondary (0-12) Supervisor College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Pearl Kelbaugh John Carl Hughes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4503 Harford Road Apt. 3A Balto., MD 21214 Elsie E. Hughes/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem. Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10.28.09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (r as a consequence of): Effusion Side Pleura as a consequence of for at ed Due to (or as a consequence of): yelitis If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \sum No 1 ☐Yes 2 ☐No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Mydical Examiner must be confined at once.

Physician

} /Medical

Examiner

John Hughes Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

HARI R. DEVINTA

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

State

31. Date filed (Month, Day,

within 2

5-003(2 hours a atural", o	eral Director	Amend #5, per FH For State Registrar 1. Decedent's Name (First, Middle, Last), 4a. Facility Name (If not institution, give st.) 5. Social Security Number 1959 6. Sex Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	treet and number) W of Built M 2 17. Age (In yrs.	Certificate CKS 4b. City, Tov Rast birthday) If Under 1 Y	of Death on, or Location of Deat hmore C	2. Date of Death Month	No.2 1 0 9 Day Year Ac. County of Death	34508 3. Time of Death 03:;25AM
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2 hc 2 hc	ਨ∣	11. Marital Status 12 1 Never Married 2 Married 3 Windowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 _Yes _2[UN] If Yes, Give Year or Dates:	If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puerl No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	can Indian,
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2 short and is m. is m. is m.	-	199. Informant's Name/Relationship (Type	e. Print) - daughter	19b. Mailing Address (St. 3821 GK)	reet and Number or Ru	ural Route Number, C	City or Town, State, Zip	Code) MD 2120
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti once.		20a. Method of Disposition 1 □ Berial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service License	moval from State A	Place of Disposition (Name of competery, crematory or other	of place) neters of acility	3/09 Z	C. Location - City or To	wn, State
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on or VItal Record ding Physician; The law requir h. After this certificate has been si funeral director, page 2 should tion: To Be Completed		Hyperten	5000			24a. Was an autopsy performer	d? death?	psy findings available mpletion of cause of 2 No
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T ing ing	Calloll.	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day, Year)	M	Injury at Work? 1 □Yes 2 □ No	28d. Describe how	injury occurred	
		4 ☐ Homicide determined	building, etc. (Specif			City or Town, S		
o the Hosp ithin 24 hou orthe Fune ompletely fil	בחונים	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	er: On the basis of examina and manner stated.	wledge, death occurred at the tition and/or investigation, in	ne time, date and place my opinion, death occu	e, and due to the causurred at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
To t To tl		29b. Signature and title of certifier	. 0 ~	29c. Lie	cense number		Date signed (Month,	Day, Year)
	3	30. Name and address of person who com	ppleted cause of death (Iten	n 23a) (Type, Print)	5-000		Rollson	10:e
State	3	SCHONZE SC 31. Date filed (Month, Day, Year)	32. Redistrar e Signa	Sina Sina	· Hospi-	tal of	NaITY	10! 6

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 8896 10/28/09 TT State of Maryland Department of Health and Mental Hygiene For State Registrar amend #12 Per ANA BD G896e 10 628 09 Death 3450 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:05 PM M 2009 Emma Jane Hanks October 0 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death William Hill Manor Talbot Easton Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 1 □ M 2 F Months Days Hours Min. Feb 14, 194-26-6365 93 1916 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No MD Talbot Oxford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 N. Morris Street Box 560 21654 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

The second Even Armed Forces?

Armed Forces?

Armed Forces?

Armed Forces. Black, White, etc. 1941-1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white Specify: 3 X Widowed 4 □ Divorced 1942 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Van Valzah Foster Emily Hartley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Randles/daughter 649 Van Alstyne Road Webster, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5☐Other (Specify) 21. Signature of Funer Service Licensee Ronald S. Warle, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cond disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗹 No 2 🗆 No y one) sidence 6 Other (Specify)

Physician /Medical Examiner The law requires that the death certificate be executed siclan and burial-trans Division of Vital Records, P.O. Box 68760, attending physiclan for use as the buria the detached

Physician

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Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumant.

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Extra all retinust be redified at

signed by t I be detach icate has been siç r, page 2 should b certificate has director, After this funeral c within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician:

To the

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown ≥ Completed 25. Be Certification: To 27.1 5 ☐ Pending investigation 1 Natural (Month, Day, Year) 2 Accident 6 Could not be 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

- CUMPILLA	1		0] 1 ☐ Yes
Was case referred to medical examiner?				_	26. Pla	ace of Death	(Check onl
1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/0	Outpatient 3	□ DOA	Other: 4 🗀	Nursing Hom	e 5∐Re
Manner of Death	28a. Date of Inju	ury 28b	. Time of		Injury at		3d. Describ

e how injury occurred 1 ☐Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check one)	, LEI MOGICAI EXAMINET. OII	the basis of examination and/or investig manner stated.	ation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
29b. Signat	ure and title of certifier	HeldodMD	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Wood, Jr. William Hill Manor, 501 Dutchmans Lane Eastn, MD 21601 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

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9036	s after des al", or ite Examiner	اج	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		If	/as Deceder Yes, specify Yes 2	Cuban,	Mexican, Puert	pecify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify:	
1215-(thin 72 hou ene, than "nati he Medica	Completed	15. Decedent's Elementary/Seconday (0-12)	ade completed) College (1-4 or 5		(Give k	NOT use re	done dur. etired)	on ing most of wor	king	16b. Ki	nd of Busines	•
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Baltimore,	. Page 1 ar ment of Ho tant: If iter lury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		ceme	etery, crem	ition (Name atory or oth ion	of er place)	10,	Date /27/09		cation - City o	r Town, State
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5	his ce I dire	유	1 Yes 2 No	Hospital: 1 lnpatie	ent 2 ER/C	Outpatient	3 □ DOA	Other:	Nursing H	ome 5 🗆 Resi	dence 6	Other (Spe	cify)
Division of Vital	after death. Director: After th I in by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		, Year)	. Time of injury	М	Injury at work? 1 Ye		28d. Describe I			
Divis	ours after death.		4 Homicide determined	28e. Place of Inju building, etc	. (Specify)					City or Tov	vn, State)		ural Route Number,
94	within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier (Check 2 Medical Examonly one) 3 Certifying Nurse 29b. Signature and title of certifier	sician: To the best of oner: On the basis of exercioner: To the basis of the basis	camination and	/or investig	gation, in my eath occurred	opinion, of at the tire	death occurred a ne, date and pla	t the time date	and place, e cause(s)	and due to the and manner as	cause(s) and manner stated. s stated.
	* > 12 %		> Sprp 2					cense nu		0		signed (Moni	th, Day, Year)
	/		30. Name and address of person who of Shekum mel	e people		(Type, Pri	Sen	ty	o Rd	Sut	e 1	100	prous
	Stat Registra	_	31. Date filed (Month, Day, Year)	3 Registra	r's Signature	Sa	de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Ruth Lillian Hoover 2. Date of Death Physician/ Month 2:30 Oct Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death 2726 W. Fairmount Avenue Date of Birm. (Month, Day, Year 29 . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min 220-18-5925 1 M 2 XF Months Director 87 MD Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examinar must have a second 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2726 W. Fairmount Ave. 21223 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ★ Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Fam. Nanny Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Matthew Stepney ည Ruth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Talbot 2726 W. Fairmount Ave. Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto. 10/26/09 Baltimore, MD Nat. Cem. Signature of Funeral Service Censee 22. Name and Address of Facility Wesley Chavis, 2007 Eastern Ave. Baltimore, 21231 23a. Part 1. Enter the disease of complications that c shock, or heart failure. List only one cause on ea complications that car he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, erval Between sort and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or linjury) Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death Month 5 Other (specify) Day Year signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \square Yes Other: 4 Nursing Home 2 D/No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Division of Vital Records, P.O. Box 68760

State Registrar

Medical

29a. Certifier (Check

only one 29b. Signature

30. Name and address of person

31. Date filed (Month, Day Year

0

0

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Riutpall)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Belle Haslup 26 2009 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Aberdeen 600 Yarish Lane If Under 1 Year 8. Date of Birth (Month, Day, Year) 10/27/1925 Birthplace (State or Foreign Country) f Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 □ M 2 🛛 F 83 219 10 5282 Yrs. Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaninar must be indiffed at 1 Tyes 2 TANO Harford Aberdeen Directo Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21001 U.S.A. 600 Yarish Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes 2 ☐XNo Specify Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Transportation Toll Collector 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk WIK ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 480 Bush Chapel Rd, Aberdeen, MD 21001 Adrianne Haslup (daughter) 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/28/2009 R.A. Ferris & Co. Pennsylvania 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. e of Functal Service 21. Sign 333 S. Parke St, Aberdeen, MD 21001 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause a each line. Do not enter the mode of dying, such p cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): Examiner 20 Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 🗌 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe has To the Hospital or Attending Physician: The certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □Yes 2 □No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur

State Registrar 31. Date filed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

		-	For State Registrar	State of Ma	ryland / I		tment of Fi ficate of I			giene Reg. No. 2 N	09 34513
	Physicia		1. Decedent's Name (First, Middle, Last) ARNOLD	I	NMAN				2. Date of De Month OCTOI		3. Time of Death 2009 11:33 PM
To have	/Medic Examin		4a. Facility Name (If not institution, give s HOLY CROSS HOSPI			4	b. City, Town, or SILVER			4c. County of MONTGO	OMERY
	Funeral Director		100 10 3733	7. Age M 2□F 93	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		av. Year)	9. Birthplace (State or Foreign Country) TENN
	filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or items 23a or 28a-f show ent, the Medical Even. Inc., 11st be notified.	Director	Usual Residence of Decedent 10a. State 10b. County DC 10e. Street and Number		10c. City, Tow		NGTON 10f. Zip Code			10g. Citizen of W	10d. Inside City Limits 1 X Yes 2 □ No That Country?
	23a or		2301 11TH STREE				20001		0 % V	USA	- American Indian,
036	urs after des al", or items Eventine	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □Yes 2 ☑N If Yes, Give Year or Dates:			is Decedent of Here is Dec	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	Specify:	k, White, etc.
21215-0036	within 72 hor ene. than "natur ne Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12TH	cation e completed) College (1-4or 5-	+)	(Give kir	NOT use retired	during most of we	orking	16b. Kind of Bu	
z pur	be filed valued Hygis of other event, the	Be	17. Father's Name (First, Middle, Last) EDWARD INMAN			1		18. Mother's Na		e, Maiden Surnam RLERSON	
Maryland	should and Mer s marke	은	19a. Informant's Name/Relationship (Ty	pe. Print)	19	b. Mailing	Address (Street			ber, City or Town,	State, Zip Code)
altimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eval. In a cust be notified an once.		COEDNA CARTER/COU		20b. Place cemet	of Disposit ery, crema	MEADOW H tion (Name of tory or other place E CREMAT	ce)	SPRING Date -28-09	20c. Location -	YLAND 20774 City or Town, State LE, MARYLAND
Balti	permit. I Departm Importal any infu		21. Signature of Juneral Service kidens	ee)			Name and Addre				NERAL HOME LAND 20785
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a HYI	RONARY a consequence PERTENS	ARTEF e of): SION	the mode of dyi		ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a DEN Due to (or as a d.	MENTIA						
O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnand Other (specify) _	су			te of delivery nnth Day Year
rds, P.	quires that n signed b	b	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the und	derlying cause gi	ven in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown
al Reco		Completed							per 1 □ Yes	opsy formed? 2 \(\overline{A} \) No	Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 ☑No
f Vita	Physician: The I r this certificate ha ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2. 🗽 ER/0	Outpatient	3 □ DOA Ott	hor:	eath <i>(Check only</i> Home 5 Re	<i>one)</i> sidence 6 ☐Oth	ner (Specify)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Inju (Month, Da 28e. Place of Inju building, etc.	y, Year) ury - At home,	o. Time of Injury farm, stree		iry at rk?]Yes 2 □No	28f. Location	e how injury occur (Street and Numb own, State)	per or Rural Route Number,
	Hospital of the sale of the sa	Medical Ce	29a, Certifier 1 ☑ Certifying Phy (Check only one)	vsician: To the best iner: On the basis o	f examination	lge, death and/or inve	occurred at the estigation, in my	time, date and pl opinion, death o	ace, and due to the	ne cause(s) and me, date and place,	nanner as stated. and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title dicertifier	and mainler sta	nivu.			se number			d (Month, Day, Year)
	St Regist	ate	30. Name and address of person who can address of person who can also a support of the support o	M.D. 971	5 MEDIO	CAL C	rint)	051280 RIVE SUI	TE 201 F	10-20- ROCKVILLE	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0ct. 27 Physician/ 2009 2:42 A Kathryn Woods Knott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Pickersgill Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F July 10 Year 1928 Mississippi 216-28-6701 81 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 💆 No Md. Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 615 Chestnut Avenue Apt. 413 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc Yes 2 X No 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or amy injury or other traumatic event, the Medical Examinance. 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Marie John William Woods Huebner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 Kurtz Ave. Lutherville, Maryland 21093 Stephen M. Knott/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 10/28/09 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events by the attending physician and stached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death sate has been signed by the a page 2 should be detached in 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) October 27, 2009 29b. Signature and title of certifie 1)25205 of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. md 21208 Q BINC 6701 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

DV

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

KEKHA MOTAGI

31. Date filed (Month, Day, Year) 2009

29c. License number D52197

GBMC 6701N. CHARLES ST., BALTIMORE, MD 21204

10-24-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 2:15P M HANNAH KATZ 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2431 HUNT DRIVE BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 08/25/1912 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 213-10-4968 97 Director Usual Residence of Decedent 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Experient must be notified all 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 📉 No Director MD BALTIMORF BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2431 HUNT DRIVE 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No WHITE If Yes, Give Year or Dates: ģ 3 XWidowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JONAS JACOBS** ပ KATE LEFKOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heatth and Important: If Item 27 Is n any Injury or other traun once. ALAN KATZ/SON 4600 MEWS DRIVE, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM CONG. 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2009 BALTIMORE, MD 22. Name and Address of FacilitSOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 JUCI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CAD years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HASCUR Yeur Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has l page 2 s autopsy performed? 1 □ Yes 2 A No this certificate of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred Certification: Injury at Work? Division Natural 2 Accident within 24 hours after community to the Funeral Director; Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5. H MACINON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2700 Quany lah

32. Registrar's Signature

00004701

29d. Date signed (Month, Day, Year)

10/23/19

Que Balfenso Met 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a.perfH,G896,10/6/09,WS
State of Maryland / Department of Health and Mental Hygiene
end Item 29d per dr.,g896,10/28/09dhb

Certificate of Death

Reg. No. 200 State of Maryland Amend Item 29d per dr., 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) OMONTH DBER Day **Physician** 3:30P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, ga give street and number, Examiner Center Baltimore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 247-84-5682 Director 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director mor 28a-f 10g. Citizen of What Country? 10e Street and Number 23a or 72 hours after death with Funeral . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced ģ 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Business Owner
(Liness Owner) Completed 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturany or other traumatic event, the Items." Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Su 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship #6 20c. Location - City Method of Disposition Burial 2 Cremation
4 Donation 5 Other (5 3 Removal from State 5 ☐ Other (Specify) ervi icensee 21. Signature of Fun 1553 NO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) SUDDEN DEATH Physician /Medical Due to (or as a consequence of): ARREST Examiner CARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical use as attending If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year ģ 5 ☐ Other (specify) 1 □Yes 2 XNo detached 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ATHEROSCLEROTIC CARDIO VASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES autopsy performed 2 X No 2 X No 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4} \square$ Nursing Home $_{5} \square$ Residence $_{6} \square$ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After this funeral of 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A sletely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/onlinestigation, in my opinion, death occurred at the time, date and place, and due to the cause of Medical 29a, Certifier and/oninvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu ٩ 8 October 2, 2009 D29931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D. CHRISTOPHER LORENTZ. 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 2009 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1.2:53 AM edric upert 10 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner niversity Baltimore Maryland Medical Corse Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months Days Hours Min Director 10a. State 10h County 10c City Town or Location 10d Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment must be restlined at Director 1 ☐ es 2 ☐ No 1th more 10g. Citizen of What Country? 10e. Street and Number USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Vivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ordary (0-12) than College (1-4or 5+) and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surf Be 1 and 2 should be ပ 19b. Mailing Address (Street and Num-Sister) 125 N.B Health a Department of Health Important: If item 27 any injury or other tr once. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ★Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Intracranial Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pancy to pani, Due to (or se a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burlal-transit Exami Liver Pailu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 ☐ Yes 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Jason Oh

31. Date filed (Month Day, Year)

Street

Green

South

Baltimore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 9:50 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 5, 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Months Days Min 1 ₹ M 2 □ F 219-70-0373 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or Items 23a or 28a-f showevent, the Medical Evaneiner must be notified at Director No Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1904 Park Avenue 1st flr 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: ģ Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry m 27 is marked other than "n, the traumatic event (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 6 temporary worker temp agency permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Eugene Linton Margaret Basey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliet Griffin/sister 1904 Park Avenue 1st flr Baltimore, MD 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signatur Funeral ervice Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Wade Director 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final hemossyage **Physician** Subarachword disease or condition resulting in death) do->5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed2 Yes 25 No certificate 2 No 1 ☐ Yes Physiclan: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 27. Manner of Death Date of Injury (Month) Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending investigation 1 Natural Injury 09 after death. 8 UNK 1 ☐ Yes 2 No 2 Accident Subject fell 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Park Ave, Baltimore 904 24 hours a nome Medical (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19805 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05:26 PM Thomas Lindler OCTOBER 2009 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death N/A SAINT AGNES HOSPITAL BALTIMORE 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 53 1**X** M 2 □ F Months Days Hours Min. 56 213-60-3134 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 Mellor Avenue 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 □Yes 2 No Specify: White If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Lindler Virginia Hilsburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 South Lambard Avenue Evansville, IN 47714 Amanda Lindler, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 10/26/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part1. Enter the disease, or of multications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of a ach line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA DAYS disease or condition resulting in death) Due to (or as a consequence of): COPD YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEPATITIS YEAR Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALCOHOL 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

law requires that the deat | certificate be executed Box 68760. THOMA Ö LINDLER, Δ. Records, Division of Vital

nding physician and use as the burial-tranfor the signed by t icate has been significate page 2 should b To the Hospital or Attending Physician: The certificate this funeral After t

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

per it. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mulical Evanting must be notified at

Physician

/Medical

Examiner

/Medical

Director

Funeral

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Be Completed

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADHIKA KALISETTI, 900 CATON AVENUE, 31. Date filed (Month, Day, Year)

M.D

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P22002

29d. Date signed (Month, Day, Year)

BALTIMORE, MD - 21229

OCTOBER, 25th, 2009

71				-	
State of Maryland /	Department	of Health	and	Mental	Hygiene

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	es ray i	LOOK	1	For State Certification	ficate of Death	Reg. No.	
led	Physical Ex	sicia amír	n/	Decedent's Name (First, Middle,Last) James Ray Locklear		2. Date of Death Month Day Year October 16, 2009	3. Time of Death 0538 hrs
)			ia. Facility Name (if not institution, give street and number) Eastern Blvd @ Eyring Avenue	4b. City, Town, or Location of Death Essex		1
	Fune Direc			5. Social Security Number 6. Sex 7. Age (In yrs. last 220 – 78 – 9326 1 XM 2 F 45	birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	1 1064 Foreig	thplace (State or gn nuntry)MD
		now any		Usual Residence of Decedent 10a. State 10b. County 10c. City, To AD Baltimore Ess	own or Location e X		10d. Inside City Limits 1 Yes 2 X No
	the Marylan	or items 23a or 28a-i show must be notified at once.	Director	10e. Street and Number 1100 Glemsford Road	10f. Zp f 29 2 1	10g. Citizen of What Cou	intry?
	death with	or items 23 must be no	~ I	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	er. IND.
	0036 within 72 hours after death with the Maryland giene.	other than "natural", the Medical Examiner	<u>a</u>	Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done ired) Specify: Ame Specify: Ame I6b. Kind of Business Private	
	Baltimore, MD 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.	ed other tha	01	12		e (First, Middle, Maiden Surname)	
	MD 212 d 2 should be Ith and Ments	1 27 is mark umatic ever	9	19a. Informant's Name/Relationship (Type, Print) Michelle Locklear	19b. Mailing Address (Street and Number or 7834 Harold Rd. Du	undalk,MD 21222	
	Baltimore, permit Pages I and Department of Heal	tant: If iten or other tra		1 X Burial 2 Cremation 3 Removal from State Mt.		Date 20c. Location - City of Dundak,	MD
	Balt permit. Depart	Impor injury	1	21. Signature of Funeral Service Licensee Wesley Charis h	2007 Eastern A	esley Chavis,Jr ve. Baltimore,M	D 21231
	Physic /Med ami	ical		Part I. Enter the disease, or complications that caused the death. If failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
			iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	cuted	nd transit	I Examiner	(Ulsease or injury una mutated events resulting in death) Last Due to (or as a consequence of):			
	O, e be exe	physician and the burial - transit	Medical	UNPENDED AMENDED		23d. Date of delive	200
	Division of Vital Records, P.O. Box 68760, To the Hospital or Vitending Physician: The law requires that the death or fifted to executed within 24 hours after death.	atter ding or u:e as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnate in the Live birth 4 Pregnant at time of deal	2 Fetal death 3 Ectopic pregr		Day Year
	P.O. B	signed by the be detached f	Š		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 ✓ No 3 Pr	
	ecords,	should	Completed				
	<u>e</u> # ∏	certificate ha ector, page 2	BeC	25. Was case referred to medical	26.Place of Death (Chec	k only one)	
	f Vit	ië ij	To E	1 V Yes Z No	ER/Outpatient 3 DOA Other Nurs 28b. Time of Injury 28c. Injury at Work?	sing Home 5 Residence 6 Ott	ner: Scene
	ion o tending eath.	ector: After the by the funeral	tion:	1 Natural 5 Pending 2 ✓ Accident Investigation	0533 hrs 1 Yes 2 ✓ No	Pedestrian struck by auto	
	Divisital or Att	·= =	Certification	3 Suicide 6 Could not be determined (Specify) Major Road	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State) Eastern Blvd @ Eyring Avenue, 1	
	Division To the Hospital or Attent within 24 hours after death	To the Funeral D completely filled i	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledg one) 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place, a	d at the time, date and place, and due to	the cause(s)
	F ≥	± 5	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (// October 16, 20	
				30. Name and address of person who completed cause of death (Item Donna M. Vincenti, MD Assistant Medical Exam		MD 21201	
		S legis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
				TABLE OF SELECTION (Market A. 1971)	- C 400 / F 541 / ST 97		

09-08286 Alan Levine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day October 25, 2009 1106 hrs Medical Examiner ALAN MARC 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Baltimore County** Randallstown Northwest Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min. Days Hours Months Director Country) NY 074-38-0804 1 **X** M 2 02-13-1948 61 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location BALTIMORE 1 Yes 2 X No MD STEVENSON or 28a-f show notified at once, Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 1805 BY WOODS LANE 21153 23а 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status 12. Was Decedent Ever in U.S. or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. permit. Pages I and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item injury or other traumatic event, the Medical Examiner must b Armed Forces? 1 Never Married 2 X Married 1 X Yes Specify: WHITE Divorced Yes 2 X No specify: Widowed Yes, Give Year ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 MEDICINE 5+ORTHOPEDIC ONCOLOGIST 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FELICE Be **PLETMAN** LEVINE LEON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBARA LEVINE/WIFE 1805 BY WOODS LANE. STEVENSON. MD 21153 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition GARRISON FOREST CEMETERY 10-27-2009 OWINGS MILLS, MD 1 X Burial 2 Cremation Other Specify Donation 5 SOL LEVINSON & BROTHERS, INC. nature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminei or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has 2 sl performed? death? Yes 2 V No 2 No certificate the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other DOA Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work's 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director:
completely filled in by the f Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide (Specify) Homicio 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) d title of certifie 29k Signature a 20 O.C.M.E. October 25, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD

31. Date filed (Month, Day, Year) State Registra

Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:00 PMM October 23, 2009 Grace Wonn Mast /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Springbrook Nursing Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Min. March 18,1905 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 104 Yrs. Pennsylvania 578-90-3951 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20017 924 Upshur St. NE United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes ZXXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify White <u>م</u> 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed.

Theath and Mental Hygle.

Yem 27 Is marked other th. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erdman Carrie William Henry Wonn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other trauonce. Phillip W. Mast / Son 809 Hobbs Dr., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 10/26/2009 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

Mod 382

Rapp Funeral and Cremation
933 Gist Ave., Silver Sprin

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician WSTANT CERCIVARY ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably HEART TAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYBERTENSION autopsy performed?

1 Yes 2 ANo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/26/2009 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Medical Center Dr., Rockville, MD Ravi Passi, MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

GRACE INFONMIMAST

ODIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34524 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:30A M Miller 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Nursing Home Vestminster ivina 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Number (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day Hours 1 M 2 XF Months 19.18.65 ØL. MD Director Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Baltimore Randallstown 1 Tes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 8608 Church Lane Funeral 21133 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry المالية المال Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event **** Silversmith Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marie Scherer 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vn4i 2581 Cedar Ridge Drive Westminster MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1

■Burial 2

Cremation 3

Removal from State Owing mub, MD 10/29/09 4 Donation 5 Other (Specify) Har Sinai Cemeter 21. Signature of Funeral Service Licensee Jugan C. Greens Funeral Sic Randallstown MD 21133 Dad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause a each line. Immediate Cause (Final Physician/ disease or condition mos Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ 3 in the past 12 months? Month Day Year signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 Tes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 XNo ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month Day, Year) 30. Name State

DHMH 17 Rev 7/2009

Registrar

1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 948 PM McNichol **Physician** OCTOBER lene 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rallimore andallstown Hospice @ North west Season's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 05-14 9. Birthplace (State or Foreign Country) Port land 7. Age (In yrs. last birthday, 6. Sex Year. **Funeral** Months 1 □ M 2 1 5Yrs. amaica 219-27-121 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widcal Examinar must be neathed a once. 1 □ Yes 2 Z No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number N. Rolling USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married 1 □Yes 2 ♥No If Yes, Give Year or Dates: Specify: Baltimore, Maryland 21215-0036 Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Medical Assistant 18. Mother's Name (First, Middle, Ma den Surname 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Green Battimare, Jub 21244 78 Mountain Benjamin/Daughter arol 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ridge Cemelony 11-7-209 Pikesville, NUD
22. Now and Address of Pillip Vaugho C. Greene Fundad STB. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Rd. Randalistour, MD 21133 iberty Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear hailure. List only one cause on each line. Immediate Cause (Final Acute **Physician** Intracranial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar CERTIFICA Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial pe Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ed by the detached f 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 □ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence ON Other (Specify) 1105PLQ Hospital: Yes Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 1 🔼 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A 2 Accident filled in by the Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Medical 29a. Certifier completely (Check only one) and manner stated the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1445931 B cause of death (Item 23a) (Type, Print) 30 Name and address of OLD COURT ROMP Debarah 5401 Dur ten

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	State Registrar		Certificate	of Death	Reg. N	10. 2 [] 0	3452
Physician /Modical		Decedent's Name (First, Middle, Last)	MUN			2. Date of Death Month	Day Year 7009	3. Time of Death 0445
/Medical Examiner Funeral Director	4	Social Security Number 6. Sex	VENTIST HOSE	PITA K ast birthday) If Under 1	wn, or Location of Death Color VIII Year If Under 24 Hrs. Days Hours Min.	_	1c. County of Death NONES 9. Birth Co. 1940 Go.	- /
vith the Maryland or 28a-f show corrollited at	1	sual Residence of Decedent Da. State 10b. County MD MONTE	437	y, Town or Location		100	Citizen of What Co	10d. Inside City Limit 1 X Yes 2 N
be filed within 72 hours after death with the Maryland mal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Ever instrument or critiled at Be Completed by Funeral Director			GLEN CO. 12. Was Decedent Ever in U.S.		ode 8 9 8 nt of Hispanic Orlgin? (Sp. Cuban, Mexican, Puerto		14. Race - Ame	rican Indian,
tural", or ite	5	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edu	Armed Forces? 1	1 ☐ Yes 2 ☐	No Specify:		Specify: A	SIAN
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should be file and Mental Hy s marked oth umatic event	1 2 2	7. Father's Name (First, Middle, Last) 5 U / \ 2 9a. Informant's Name/Relationship (Ty	V1UN	19h Mailing Address (18. Mother's Nam Solution Street and Number or Rui	e (First, Middle, Maid	VA	Zip Code)
Jes Fallo 2 S t of Health ar If item 27 is or other trau		UONNTHON MUN Da. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	N - SGN Removal from State	22 OWE/IJS	GLEN COURT	CAITHER Date 200		1d 20878 Town, State
Department Important: If any injury o	2	4 □ Donation 5 □ Other (Specify) 11. Signature of Funeral Service License			Address of Facility ffs.	WORD FUI	NEKAL A	Ham on
hysician /Medical	11.	23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or mmediate Cause (Final isease or condition esulting in death)	ications that caused the death ne cause on each line. a. Due to (or as a consequence)	n. Do not enter the mode	of dying, such as cardiac	or respiratory alrest,		Approximate Interval Between Onset and Death
g physician and ss the burial-transit and edical Examiner	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֡֓֡	Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	Due to (or as a consequence). Due to (or as a consequence).	ALTERY E	PISEMSE			XUARS_
		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 D Ectopic pre			23d. Date of de Month	livery Day Year
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fler this certificaneral director, In To Be C		1 Yes 2 1 No 17. Manner of Death 1 1 Natural 5 Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury M	Other: 4 \sum Nursing H c. Injury at Work? 1 \sum Yes 2 \sum No	autopsy performed 1	prior to death? No 1 □ Yes e 6 □ Other (Spe	completion of causes s 2 □ No scify)
ter this certific ineral director, I	Certification: 10 be	examiner? 1 Yes 2 No It 1. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At hobuilding, etc. (Specification)	28b. Time of Injury M 28 come, farm, street, factory, (1/2)	Other: 4 Nursing H c. Injury at Work? 1 Yes 2 No	autopsy performed 1 □ Yes 2 ₺ th (Check only one) ome 5 □ Residence 28d. Describe how i 28f. Location (Stree City or Town, S	ir prior to death? INO 1 □ Yes e 6 □ Other (Spenjury occurred t and Number or Ritate)	completion of cause s 2 □ No ecify) ural Route Number,
this certificate has been all director, page 2 should	ledical certification: 10 be	examiner? 1	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At he building, etc. (Specifier: To the best of my knother: On the basis of examina and manner stated.	28b. Time of Injury M 28 28 28 28 28 28 29 29 29 29 29 29 29 29 29 29 29 29 29	Other: 4 Nursing H c. Injury at Work? 1 Yes 2 No office It the time, date and place in my opinion, death occu-	autopsy performed 1 □ Yes 2 ☑ th (Check only one) ome 5 □ Residence 28d. Describe how i 28f. Location (Stree City or Town, See, and due to the cause rired at the time, date	prior to death? No 1 Yes 2 6 Other (Spennjury occurred	ural Route Number, us stated. e to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 26 2009 6:54 A Τ. McNea1 James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 215 38 9598 1XX M 2 . F 73 00006e1ay 12ar 1936 Balfciffore County, MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2XX No Marvland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21221 USA 517 Theresa Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1XX Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3√X Widowed 4 □ Divorced Year or Dates. 1955~1957 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louisa Mohr George McNeal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Fairlane Road Bel Air, Maryland 21015 Dawn M. Pridgeon (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XX Burial 2 Cremation 3 Removal from State October 30 2009 Zion Church Cem. Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility.

Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre-Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) m clis Medical Due to (or as a consequence of): Examiner N husis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Dusito (or as a curresqueries of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? Yes 2 X/No 1 🗌 Yes 2 🗆 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29a. Certifier

(Check

only one) 29b. Sign

31, Date filed (Month D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

(9701

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

N. Chaples ST

29d. Date signed (Month, Day, Year)

OCTOBER

26 2000

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:00P M Martha Elizabeth Miller 2009 September /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mandeville House Waldorf Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Feb 1, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) 1 □ M 2 🖵 F 93 Yrs 1916 North Carolina Director 403-09-7398 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Evaninat must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1XYes 2 No Directo Charles Waldorf MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13930 Mount Eagle Lane USA 20601 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No SpecifyWhite δ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Christena Kennedy Edward P. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13930 Mount Eagle Lane 19a. Informant's Name/Relationship (Type. Print) waldorf, MD 20601

20b. Place of Disposition (Name of cemetery, crematory or other place)

Howard University Mollie M. Thorn/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/6/09 Washington, DC 4 X Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Sen M00996 DC 20011 3821 14th Street NW, Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Daw to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗓 No ρ 5 Other (specify) 9 Unknown icate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2**X** No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Anursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: filled in by completely

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

(Check only one)

Michael

cal

Sidarous, MD 11701 Livingston Road #101, Fort Washington, MD20741 82. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D45365

29d. Date signed (Month, Day, Year)

10/6/09

sobby Montgome		State of Maryla I-For State Registrar	nd / Departm <i>Certific</i>			Mental F		g. No. 21	109 31.52
Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
Medical Examin	ier	Bobby Montgomery 4a. Facility Name (if not institution, give street and nu	mher)	141	. City, Town, or Lo	cation of Deat	Month October 2	1, 2009 4c. County of	1632 hrs
		Maryland General Hospital	in Bory		Baltimore			N/A	2020.
Funeral	T	5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year				Birthplace (State or Foreign Country)
Director		220-64-8500 1XM 2_F	54	Yrs.	Months Days	Hours Mi	12/20	/1954	MD.
япу	Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Locatio	n				10d. Inside City Limits
A		Md. N/A Baltimore						1 XYes 2 No	
Maryland 28a-f show		10e. Street and Number 10f. Zip Code 10g. Citizen of What Co						t Country?	
h the h	₫	3812 Elmora Avenue			2121			USA	
ath wit	nera	11. Marital Status 1 Never Married 2 Married Armed Formula			Decedent of Hispa s, specify Cuban, N			14. Race - White,	American Indian, Black, etc.
frer de		3 Widowed 4 Divorced If Yes, Give Yes	2 X No	1 ,	Yes 2 X No	specify:		Specify:	Black
nours a	å b	15. Decedent's Education (Specify only highest grad	de completed) 16a	. Decedent's	s Usual Occupation	n (Give kind of		16b. Kind of Busi	
36 in 72 l han "r	틢	Elementary/Secondary (0-12) College (1				.0 110 / 050 10	·	Dmirzo+o	Componer
ed with ygene other t	Completed	17. Father's Name (First, Middle, Last)	100	onsti	cuction 18	.Mother's Nam	ne (First, Middle, N	1	e Company
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	Robert Montgomery				Cathe	erine	Gross	
MD 2: td 2 should Uth and M m 27 is ms aumatic e	의	19a. Informant's Name/Relationship (Type, Print) Laverne Montgomery	L.	-	Address (Street a			•	
nore, MD 21215-0036 spess I and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene. 1: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	ŀ	20a. Method of Disposition	20b. Place	of Disposit	ion (Name of ceme		Date Date		e , Md . 21202 City or Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal fr 4 Departion 5 Other Specify:	on otate	ntory or other	erplace) cematory	v 10)/29/09	Catons	ville, Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	İ	21. Sign fure of Fundal Service Licensee			respectations Europe				
		23a. Part I. Enter the disease, or complications that c	DIELLY		L300 Eu	taw Pl	ace, B	altimor	e, Md.21217
Physician /Medical		failure, List only one cause on each line.	- V				or respiratory are	est, shock, or near	t Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Na reo Due to (or as a	ic (morph: consequence of):	ine)	intoxicat	tion			
, mill	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):						
	틝	Co	,						
St. Ed.	events resulting in death) Last Due to (or as a consequence of):								
60, are be executed hysician and e burial - transit	sician/Medical	XUNPENDED 23a,27,28a-f, perME, g897 11/10/09 TT							
760, icate be physici the buri	₩e	2h Mac decedent programmet in the	outcome of pregnancy	y		_		23d. Date of c	,
Box 6876/c death certificate the attending phy of for use as the b	cian	past 12 months?	i rth ant at time of death	- =	al death 3 _ er (Specify)	Ectopic pregr	nancy	Month	Day Year
BO)	剷	1 Yes 2 No 9 Unknown 9 Unknown							
P.O.							Probably 4 V Unknown		
ords, P	sted	-					24a. Was	an 24b. W	ere autopsy findings available
e law re has be ge 2 sh	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1						rior to completion of cause of eath?		
tal Rec	25. Was case referred to medical 26.Place of Death (Check only one)							2 NO 1	Yes 2 No
Vita hysicis this ce	٥	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:							Other:
n of ding Ph	u o		of Injury 28b , Day,Year)	. Time of In		at Work?	28d. Describe I	how injury occurre	d
Sion Attend or death rector: by the	cati	2 Accident Investigation Fd 10		: unk	nown			Street and Numbe	r or Rural Route Number. City
Division ospital or Attent hours after death hours after death inneral Director: y filled in by the	Certification:	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) other: hospital 28f. Location (Street and Number or Rural Route Number, City or Town, State) Maryland General Hospital, Baltimore, MD							
e Hosp n 24 ho e Fune letely f		29a. Certifier 1 Certifying Physician: To the bes					nd due to the caus	e(s) and manner	as stated.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
		Commission and the or obtained	A		O.C.M			October 22,	
1	-	30. Name and address of person who completed cause	se of death (Item 23a)						
ox pend	1	Zabiullah Ali, M.D. Assistant Medic	al Examiner 1	111 Penr	Street, Baltin	nore, MD 2	1201		
Sta Registr	te ar	31. Date filed (Month, Day Year) 2 8 200 32. Re	egitrar's Signature	1. 4	and				
	_			3 67					

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 10/25/2009 Year Laura Martin **Physician** 11:22a ^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bowie, MD Prince Georges Larkin Chase Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 448-20-3834 1 □ M 2√2 F 88 6/6/21 OK Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ves 2 □ No Alexandria Alexandria VA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1050 N. Royal Street 22314 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Michael Even inconce. 1 ☐ Yes 2★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: white þ **3**Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Office 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Suzanna Martins John Heinrichs ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul Martin / Son 1050 N. Royal Street, Alexandria VA 22314 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sunset Memorial Park 10/30/2009 North Olmsted, OH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Victor P. Doda, Jr 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia / Altz. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ye ar 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performe 2 **N**0 2 No certificate 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: After (Month, Day, Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43351 10/26/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ikechi Fred Okwara 6201 Greenbelt Rd Suite U15, College Park MD 20740 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10/24/09 4:00a M Physician Molinari /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Healthcare Belair Harford Date of Birth (Month, Day, Year) 7/26/1920 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 015-18-2425 **1** M 2□ F 89 MA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the 'n oral Examinar must be notified at 1 ☐ Yes 2 No Forest Hill **Funeral Director** Harford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21050 USA 1602 Deborah Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. army 1XXYes 2 □ No 1 Never Married Married 42 - 45Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2KXNo White Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Paul Molinari Maria Defonzo မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Deborah Court, Forest Hill MD 21050 ^{19a.} Informant's Name/Relationship *(Type. Print)* Elizabeth Molinari / Wife permit. Pages 1 and 2:3 Department of Health a Important; if item 27 is any injury or other trau once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State St. Mary Cemetery 10/28/2009 Mansfield MA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Myscar Sequentially list conditions, Due to (or a a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Ö 9 Hunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 DA 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier aun (nem 23a) (Type, Print)
500 Uffer Chesafeake Dri 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2009 1 - For State Registrar 34532 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** 11:35 AM Donna Ann Morgan UCTUBER 23,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore N/A | Hounder 1 Year | Hounder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | Rebruary 19, 1954 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 55 218-68-7631 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ir than "natural", or items 23a or 28a-f show the Medical Expresser mast be restified at 1 □Yes 🏖 No Director Havre De Grace Maryland Harford with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 1932 Chapel Road 21078 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Market and Once. 1 ∐Yes 2XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specifywhite ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Dog Grooming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Janet L. Chalmers Atkinson John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1932 Chapel Road, Havre de Grace, Maryland 21078 <u>Barry J. Morgan/ Husband</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) October 26. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HEPATORENAL SYNDROME /Medical Due to (or as a consequence of): Examiner LIVER FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed LIVER CIRPHUSI physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as attending I for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛮 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AT 2438946 MD OUTOB ER

State Registrar

DHMH 17 Rev 1/2001

UNION MEMORIAL HUSPITAL, BALTIMOREIMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

28 2009

31. Date filed (Month, Day, Year)

TOG

PARK, MD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 25^{Day} 2009 Year Dorothy Phyllis Myers 11:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Iutherville Stella Maris Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Months Days Hours Min 83 Director Maryland 214-22-6766 Sept. 28 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 No Columbia Howard Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be Funeral with 1 items 23a 11529 Little Patuxant Parkway 21044 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 👿 No Black, White, etc. þ 1 Never Married 2 Married than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 N Divorced 25,2009 Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Real Estate Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည S. Herbert Wareheim Helen unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Kristin Myers/Granddaughter <u>10609 High Beam Court, Columbia, Maryland 21044</u> any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 26. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. natory, Inc 2009 Baltimore, Maryland
22. Name and Address of Facility Cremation Society of Maryland, Inc. . Signature of Funeral Service Licensee Arranda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

28 2009

TIMONIUM

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 1:00a October 6 1 23 N. Middleton Mary /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Poplar Avenue 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Hours Months Min. 1 □ M 2 1 F April 29, 1921 Maryland 88 218-22-3657 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ¥ Yes 2 □ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21224 7609 Poplar Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21☑ No Specify: White If Yes, Give Year or Dates: Specify 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Lindamood unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7609 Poplar Avenue, Baltimore, Maryland 21224 Arlene Pedrick/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 23. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of FacilitCremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Cancer Colorecta disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncompage Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed

Physician /Medical Examiner

death certificate be execute

P.O. Box 68760,

Division of Vital Records,

Physician

Funeral

Director

28a-f show

d other than "natural", or items 23a or 28a-f show event, the "Adical Examiner must be notified at

721

12 should be filed w h and Mental Hygier ' is marked other th

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

Examiner burial-tran and physician the burial Physician/Medical use as t for signed by the a d be detached fo þ Completed this certificate has al director, page 2 s spital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa Be Certification: To

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 1 ☐Yes 2 X No

25. Was case referred to medical		26. Place of Death (Check only one)						
examiner? 1 ☐ Yes 2 🙀	No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3	□ DOA	Other: 4 Nursing H	lome 5 X Residence 6 ☐ Other (Specify)		
27. Manner of Dea 1 X Natural 2 Accident	th 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		ome, farm, street, fa	actory, off	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier						e, and due to the cause(s) and manner as stated.		

	one)	2	Wedical	⊆X411
29b.	Signature an	d title	of certifie	r

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MD

ZUUS

29c. License number P53590

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

October 23, 2009

21205

MO

24 hours a

31. Date filed (Month, Day, Year)

32. Registrar's Signature racks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

634 N BLOADWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28b per ME g896 10/28/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TRauma BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | May 03 1916 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 212-18-5263 Usual Residence of Decedent 5263 1 □ M 2 🕱 F 93 Director Yrs. MARYLAND 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Nedeal Evan and rust be notthed at ARYland Yes 2 No Director HIMORE 10e. Street and Number 10g. Citizen of What Country? GROVE USA Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by 3 ₩ Widowed 4 □ Divorced African AMERICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kin of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 124 OWN HOME Domestic WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any Injury or other tra BAHIMORE, HARYLAND 21216 Ann 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City of Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Oct, 30,2009 Catons Ville, MARYland METRO Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address & Facility Funeral Service NANCY M. WALLACE FUNERAL SERVICE STORM WILLIAM 21339 ature of Funeral Service Licensee 23a. Pand File he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h in tailure. List only one cause on each line.

Immediate Caus (Final disease or condition resulting in death)

a. Subdural Hema-toma. **Physician** /Medical Due to (or as a consequence of) Examiner ALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cl as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed this certificate 1 ☐Yes 2 🗷 No 1 ☐Yes 2 ☐ No of Vital Physiclan; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After t 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1
Natural 5 Pending death. FAIL 10-10-2009 unknown M 2 Accident investigation 1 ☐ Yes 2 ☑ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Bural Route Number, City or Town, State) 1229 Poplar Grove St BAHIMOTE, Md 21316 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ELLOW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE BALTIMORE MO 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCE 3:30 PM Physician/ 2009 Leon Mason Medical 4c. County of Death a. Facility Name (if not institution, give street and number) Town, or Location of Death 4b. City, Examiner Baltimore Riverview Nursing Home Essex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** MD Country) Days oct.29 Hours 218-18-5851 1 🔀 M 2 🗆 F 85 1/923 Director Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director Baltimore 1 🗌 Yes 🗶 No MD Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1715 E. Eager Street, Apt. 324 21205 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? ty☐ Yes 2 ☐ No If Yes, Give þ 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Wildowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) within 7 Chauffeur School Bus 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Stephen Atkinson Daisy Mason permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke. any injury or other traumatic e traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1715 E. Eager St. Baltimore, MD 21205 Marshia Mason (Daughter) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition crownsville VA Cem 10/23/09 Crownsville,MD 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. 21. Signature of Funeral Service Licenses 2007 Eastern Ave. Baltimore, MD Approximate ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PERTEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last attending physician and for use as the burial-trar ERPARATHYROLDISM Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical examiner? 24 hours after death.

Funeral Director; After this certificeted filled in by the funeral director, i 26. Place of Death (Check only one) Be Other: Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Latural work? 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Hospital 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 32. Registrar's Si

2 Marke

			State of N 1 - State Registrar		rtment of Health a tificate of Death			09	34537
ı	Physicia /Medic		Decedent's Name (First, Middle, Last) RHEA	MILLER		2. Date of Dea Month OCTOBE	Day	Year	8:15 A M
	Examin		4a. Facility Name (If not institution, give street and number COURTLAND GARDENS	er)	4b. City, Town, or Location of BALTIMORE		4c. County BALTI	MORE	
	Funeral Director		5. Social Security Number 218-09-9518 6. Sex 1 M 2 1 F 7.	Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 2 Months Days Hours	8. Date of Bir (Month, Date of Amount) 04 – 26 –	th ly, <i>Year)</i> 1919	9. Birthplac Country,	e (State or Foreign
	Aaryland f	.or	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE	10c. City, Town or Loc				1	Inside City Limits 1 ☐ Yes 2 No
	or 28a-	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of V	What Country	?
õ	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Paritial Exeminations to a refined at	y Funeral	7920 SCOTTS LEVEL ROAD, RC 11. Marital Status 1 Never Married 2 Married 12. Was Decede Armed Force 1 Never Married 2 Married 1 Never Married 1 Never Married 2 Married 1 Never Married	nt Ever in U.S. 13. v s? I No	21208 Nas Decedent of Hispanic Original Yes, specify Cuban, Mexican, □ Yes 2 No Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	USA 14. Rac Blac Specify	ce - American ck, White, etc.	
215-0036	within 72 hours jiene. r than "natural"; In Pradien Ere	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Date 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	16a. Deced	dent's Usual Occupation kind of work done during most DO NOT use retired) PERSON	of working	16b. Kind of B	usiness/Indus	
[Z D	filed wi I Hygier other the ent, Inc	Be Cor	17. Father's Name (First, Middle, Last)	SALES		r's Name (First, Middle			·
yland	should be find Mental marked or martic eve	To B		OLDBERG 405 Mallin	ROSAL ng Address (Street and Numbe			State Zin Ci	ode)
ĭ Zaa	and 2 sh ealth and n 27 is n her traun		19a. Informant's Name/Relationship (Type. Print) MORTON KESLER/NEPHEW		PHILIPS HWY.,	SUITE 104,	JACKS01	NVILLE	, FL 32256
Baltimore,	Pages 1 annent of Hernert If Item		20a. Method of Disposition 1	ARLINGTON	CHIZUK AMUNO	Date 10-26-2009	20c. Location	ORE, M	D
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility 900 REISTERSTO				
	Physician /Medical Examiner	٠,		h line.	ter the mode of dying, such as	2 2 1	arrest,	l Ir	upproximate riterval Between Disset and Death
8760,	icate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	as a consequence of):					
O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant 1 Live bir	nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			ate of delivery lonth D	y nay Year
ds, P.	uires that t signed by d be deta	ğ	Part II. Other significant conditions contributing to dea	th but not resulting in the u	inderlying cause given in Part I		tobacco use cor Yes 2 1 No		cause of death?
Vital Record	sician: The law requires that the certificate has been signed by th rector, page 2 should be detache	e Completed	25. Was case referred to medical		26. Place	24a. Waaute peri 1 □ Yes	opsy formed? 2 DNo	. Were autops prior to com death? 1 ☐ Yes 2	sy findings available pletion of cause of
Division of Vi	Phys this aldi	ation: To Be	27. Many r of Death 1 Matural 5 Pending (Month) 2 Accident investigation	Day, Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □	No	how injury occu	ırred	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:		f Injury - At home, farm, st , etc. <i>(Specify)</i>		City or To	(Street and Nun own, State)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	sis of examination and/or i	th occurred at the time, date a nvestigation, in my opinion, de	nd place, and due to the ath occurred at the time	e cause(s) and re e, date and place	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	share	29c, License number	40	29d. Date sign	ied (Month, D	yay, Year)
			30. Name and address of person who completed cause	of death (Item 23a) (Type	Print) KHT	Ave, B	ALT, 1	U0 :	1015
	St	ate	31. Date filed (Month, Day, Year) 32. Je	gistra/s Signature	barkel				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ELSON **Physician** ARIANN 0300 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 90 Market Street Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/23/1933 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 471-32-0083 Director 76 MN Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28e-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28e-f show traumetic event, the Modest Examiner must be notified at Funeral Director TN 1 ☐ Yes 2X No Shelby Memphis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2559 McVay Road 38119 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 Ō No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 □Yes 2XDXNo White Completed by 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laurence Koalska Rose Schleifer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5030 Gardner Drive; Alexandria, VA 22304 Jon Nelson, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If It eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniformed Sers. Univ. 10/23/2009 4☐Donation 5 ☐Other (Specify) Bethesda, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Se 933 Gist Avenue; Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** MAIN MUN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed s after dearn.
ral Director. After this cerum. 1 ☐ Yes 3 ☐ No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) MW. 2 No Other: 4 Nursing Home 5 Residence 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type Name and address of person wh 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Baltimore, Maryland 21215-0036

₩,09289 xoB

Division of Vital Records.

DHMH 17 Rev 1/2001

			For State Registrar	ate of Maryland		artment of H rtificate of L			eg. No. 2009	34539
			1. Decedent's Name (First, Middle, Last)				f	2. Date of Death Month		3. Time of Death
	Physicia /Medic		John B. Nolan	Ir.				GCT	72 200	9 6-15 P M
de	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or			4c. County of Dea	th
1			ST. AGNES HOL	PITAL			TIMORE		N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 13)	Year) 9. Bii	rthplace (State or Foreign ountry)
	Director		218-70-2244	53	115.			Nov. 13,	, 1955 Mar	yland
	and w		Usual Residence of Decedent 10a, State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Aaryli f sho	ō	Maryland Baltimore		Caba					1 □Yes 2 No
	the N	Director	Maryland Baltimore 10e. Street and Number		Caro	nsville 10f. Zip Code		1	0g. Citizen of What C	ountry?
	3a or	Ö	207 Brookside Drive			2	1228		United St	ates
	death ms 2	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S	3. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Am	erican Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Eventral must be redified at once.		1 Mover Married 2 Married 1	med Forces? ⊒Yes 2 ₩ No Yes, Give ear or Dates:	i		Specify:	nicari, etc.)	Black, Whi	hite
Maryland 21215-0036	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced Ye 15. Decedent's Education		16a Dece	dent's Usual Occup	ation		16b. Kind of Business	
Ϋ́	n 72 n "na"	Completed	(Specify only highest grade com	pleted)	(Give	kind of work done of DO NOT use retired	luring most of worki			•
7	withi iene. thar	E O	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)]	Never Wor	ked		Disab	led
ğ	filed Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	Maiden Surname)	
<u>a</u>	ld be lental ked ic ev	O.	John B. Nolan, Sr.				Elizabe	th A. S	taub	
яſ	shou ind N i mar i mat		19a. Informant's Name/Relationship (Type. Pr	rint)	19b. Maili	ng Address (Street			, City or Town, State,	Zip Code)
ž	nd 2 alth a 27 is		Elizabeth A. Nolan/	Mother	207 B	rookside	Drive Cat	tonsvill	e, Marylar 20c. Location - City o	nd 21228
ē,	s 1 a of He item		20a. Method of Disposition	20b. Pl	lace of Dispo	osition (Name of matory or other plac	e) Oatab	Date	20c. Location - City o	r Town, State
Ë	Page nent d nt: If nry or		1 ☐ Burial 2 X Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	ro Cre	ematory T	nc. Octob	er 23,	Baltimore.	Maryland
altimore,	mit. partn porta y inju		21. Signature of Funeral Service Licensee	nanda Heast	25	2. Name and Audres	ss of Facility Cre	nation S	ociety of M	Maryland Maryland, Inc.
m	B a E a		Au lels	nanda neast	29	99 Frederi	ick Road,	Baltimo	ore, Maryla	and 21228
	_		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death	. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
4	Physician	7. 1	Immediate Cause (Final disease or condition		PNE	UMONIA				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ience of):					
	Examiner		Sequentially list conditions b. —		C	OPD				YEARS
	D #	Examiner	cause. Enter Underlying	Due to (or as a consequ	ience of):					
	icate be executed physician and the burial-transit	Eam.	Cause (Disease or injury that initiated events c	B						
30,	oe ex cian a	<u> </u>	resulting in death, East	Due to (or as a consequ	ierice oi).					
68760,	cate o	edical	d							
9 ×	sertific ding p	/Me	IF FEMALE:	ves, outcome of pregna	ncv				23d. Date of d	olivery
Вох	atten atten for us	ian	in the past 12 months?	Live birth 2 Fetal	death 3	☐ Ectopic pregnanc☐ Other <i>(specify)</i> _	у		Month Month	Day Year
o	res that the death certificing be detached for use as	Physician/M		Unknown	eatii 5t	Other (specify)				
σ.	that t led by detar	유	Part II. Other significant conditions contribut	ting to death but not resu	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	uires 1 sign 1d be	d by						1 □ Y	es 2□No 3□	Probably 4 Unknown
000	w requir been s should	Completed						24a. Was a		autopsy findings available
æ	he lar e has ige 2	Ę.			_			autops	sy prior t med? death 2☑No 1 ☐ Ye	
ta	ilcian; Th certificate ector, pag		25. Was case referred to medical				26. Place of Deat			35 27_INU
>	ysicia s cer direct	o Be	examiner? 1 Yes 2 No Hospit	al: Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 □ Nursing Ho	ome 5 ☐ Resid	ence 6 Other (S	pecify)
<u>6</u>	ding Phys n. After this funeral di	n:T		Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Injur	y at	28d. Describe h	ow injury occurred	
<u>ö</u>	ndin ath. r: Aft e fun	atio	1 Natural 5 Pending 2 Accident investigation	(World), Day, Tear)	injury		Yes 2 □No			
Division of Vital Records,	er de; recto by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	le. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
Ö	talon rs aft al Di	Cer								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner:	On the basis of examina	wledge, dea tion and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	o the vithin 2 o the o the complex	Med	one) a	and manner stated.		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
	F 5 F 0		A whotet			P	24067		october	22,2009
	1		30. Name and address of person who comple	ted cause of death (Item	n 23a) (Tvpe	Print)	_ ,			22, 2009 MD 21229
	4~		ALWINFAA KHAT	IB 9	00 (ATON 1	TYENNE	BALT	IMORE,	MD 21229
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	wall of				
	Registr		OCT 28 2009	News B	1. 136	2				

DHMH 17 Rev 1/2001

NOLAW, SOUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 22, 2009 Pohlhaus October Dennis <u>Michael</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 10 Rumford Rd. Unit 302 Catonsville 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 13, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Mary land Days **X**□ M 2 □ F 1948 61 220-46-3821 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County works 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it e Medical Emirine must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nature." any injury or other traumatic events. USA 21228 10 Rumford Rd. Unit 302 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Field Technician Bio Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Mary Pohlhaus Bernard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Rumford Rd. Unit 302, Catonsville, MD 21228 M. Denise Pohlhaus (Wife) 20b. Place of Disposition (Name of cemetery, cremator or other place)
Baltimore Crematory
@ Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lic 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death

Mon No Immediate Cause (Final Cance 3 Physician Liver disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner inhosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No certificate 1 ☐ Yes 2 ☐ No After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar Rolling Road

Catonsville, Maryland

ruite

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:22 Physician/ OCT 2009 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NΑ BALTIMORE GILCHTIST Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) MAR, 10, 1935 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Social Security Number **Funeral** Months Hours 1 🗆 M 2 🗷 F 060-30-0324 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State Director 1 ⊈ Yes 2 □ No BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 21218 Funeral U.S.A 1040 E. STITEET 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: BLACK If Yes, Give Year or Dates. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) FEDERAL GOVERNHENT CLERICAL Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FANNIE HAMMOCK BERKLEY WINN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AFAYETTE W. PHILLIPS - SON DAK LEAF Dr. APT 2018 SILVER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🗐 Removal from State WoodLAWN, Md 11-2-09 Wood LAWN CEM 4 ☐ Donation 5 ☐ Other (Specify) 2 Name and Address of Facility PARKET FUN HEME 35/2 Frederick Ave., BALTO. MD. 21229 21. Signature of Funeral Service Licensee Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (as a consequence of): Examiner Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 NNo Month Day Pregnant at time of death Other (specify) 9 Unknow 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Phillips,

Baltimore, Maryland 21215-0036

2009

		24a. Was an autopsy prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{V} \) No \(1 \text{ Yes} \) 2 \(\text{ No} \)
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 Yes 2 No	Hospital: 1	ing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 N	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	e 290 Place of Injuny - At home farm street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
OCT 28 2009 32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct 21, 2009 2:30p ESSIE MUE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 129 West 29th Street--Apt 12a Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2√□ F Months Hours (Month, Day, Year Country) So.Carolina Director Jun 15, 1916 220-20-8269 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 ☐ No N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 U.S.A 129 West 29th Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", Specify. Black 3 ₩ Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Marshall Damon Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8721 Blairwood Road Baltimore, Maryland 21236 Quester Campbell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Page 1 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 10/27/09 injury 4 Donation 5 Other (Specify) Woodlawn Cemetery & Chapel 21. Signature of Funeral Serv 22. Name and Address of Facility any Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acure myoca DA Medical resulting in death) Due to (or as a consequence of) **Examiner** 30 4 FAMAR かかかのらいいかりかって Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami HYPER CHO WEREDOLEMI that initiated events Due to (or as a consequence of) resulting in death) Last ending physician are use as the burialthe burial-Physician/Medical HYPERPENSION Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy atter for u Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by Records, cate has been sig page 2 should b 2 ☐ No 3 ☐ Probably 4 🕦 Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No Yes Physician: Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🌠 No ၉ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or ð 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending Division 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29d. Date signed (Month, Day, Year) 29b re and title of certifie 3040 0

Registrar
DHMH 17 Rev 7/2009

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BALL MOHE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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A. Wingson

31. Date filed (Month, Day, Year)

		For State Registrar	State of I	Maryland / [rtment of H		nd Men		giene Reg. No. 2	nna	31	.541
		Decedent's Name (First, Middle	e, Last)						Date of Dea	ith	Year	3. Time	of Death
Physic /Med		Michael Joseph	Pelczar						tober	Day	2009	4:30	P M
Exami		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City, Town, or	Location of	Death		4c. Cou	nty of Death		
		300 Avalon Farm	Lane			Chester				Que	en Ann		
Funera		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. [Min (Date of Birtl Month, Day an 28	h v, Year)	Cou	intrv)	e or Foreign
Director		125-22-0418	X W Z L T	93	Yrs.			Já	an 28	, 1916	Mary	lánd	
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Lo	cation						10d. Inside	City Limits
Maryl fsho	ğ	MD Queer	n Anne's		Ke	nt						1 □ Y€	es 2 No
the 1	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	
3a of	D	300 Avalon Far	m Lane			216	519			U	SA		
IOTE, INICITIES A LICE 13-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Maryland Examiting must be notified at	Funeral	11. Marital Status	12. Was Decede		13. \	_L Vas Decedent of Hi f Yes, specify Cuba	ispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)		Race - Ameri		
rs afte	by Fu	1 ☐ Never Married 2 ☐ Man		□No es: ¶42 – 44	1	□Yes 21 No	Specify:			Spe	ecify: wh:	ite	
3-UUSO 72 hours aff natural", or	pa		it's Education		. Deced	lent's Usual Occup	ation		-		f Business/Ir		
CITO	Completed	(Specify only highe	st grade completed)	25 E.V	(Give life. L	kind of work done o OO NOT use retired	during most (i)	of working					
y with yiene giene r tha	E	Elementary/Secondary (0-12)	College (1-4-			profess	or			C	ollege		
d be filed ental Hyg red othe	Be	17. Father's Name (First, Middle,	Last)			•		's Name (Fil	rst, Middle,	Maiden Surr	name)		
should be fund Mental I smarked of umatic eve	년 교	Michael J. Pel	.czar				Jose	phine	Pole	c			
2 shot and he is ma	-	19a. Informant's Name/Relations		19b	. Mailir	g Address (Street	and Number	r or Rural Ro	oute Numbe	er, City or To	wn, State, Z	ip Code)	
e, Mi		Michael R. Pel	czar/son	2.	523	Dugdale	Lane	Chest	ertow	m, MD	2162	0	
DallIIIIOre, permit. Pages 1 ar Department of Hee Important: if item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation	2 Dameural from St.	20b. Place o cemete	f Dispo	sition (Name of natory or other plac	re)	Date		20c. Location	on - City or T	own, State	
diffilling rank. Pages partment of portant: If ite portant: If ite y injury or of ce.		4 ☑ Donation 5 ☐ Other (S		ate			- !						
Dallilling permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service ROПа1d	Licensee Di	rector	St	. Name and Addres	ss of Facility	ard 6'	55 W.	Balti	more 9	Street	<u>.</u>
		Jun 1	MULL		Ra	ltimore.	MD 2	1201					
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause on each	sed the death. Do	not ent	er the mode of dyin	ng, such as c	cardiac or re	spiratory a	rrest,		Approxim Interval E Onset ar	Between
Physician		Immediate Came (Final disease or condition	Ch	11610 VAIL	1100	- Acur	7					246	
/Medical		resulting in death)	Due to (or	as a consequence	of):							•	
Examiner		Sequentially list conditions.	b										
ed sit	i e	Sequentially list conditions, cause. Enter Underlying	Due to (or	as a consequence	of):								
ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or	as a consequence	of\-								
cate be executed physician and the burial-transit		, southing in death, date	Due to (or	as a consequence	OI).								
ocate cate physi	dical		d										
as as	Physician/Me	IF FEMALE:	23c If yes outco	me of pregnancy						224	Date of deli	ivon	
box eath ce attendii for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 Fetal death		Ectopic pregnanc	у			23u.	Month	Day	Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknov		36	Johner (Specify)							
that the led by deta		Part II. Other significant conditi	ons contributing to dea	th but not resulting i	n the u	nderlying cause give	en in Part I.		23e. Did to	obacco use o	contribute to	the cause	of death?
v requires to been signer should be considered.	d by	AduLT 0	NIT T	Diabetes					1 🗆 🗅	Yes 2☑N	0 3 □ Pr	obably 4[Unknown
v req	Completed	14 50 00							24a. Was	an 2	4b. Were au	topsv findin	gs available
ne lav e has	E G	1/4/100/00	710-2					_	autor	osy rmed?	prior to death?	completion o	of cause of
VILCII Iclan: Ti certificate ector, pa	ပိ	25. Was case referred to medica	1				OC Disease	of Death (C	1 🗆 Yes	2 No	1 ∐Yes	2 1 0	
s cert	o Be	examiner? 1 Yes 2 No	Hospital:	patient 2 ☐ ER/O	utnation	oth	Or:			dence 6	Other (Spa	oifu)	
P P G	Ë	27. Mann f Death	28a. Date of	Injury 28b.	Time of					how injury oc		эпу)	
ding th. Afte	ţi	1 Natural 5 □ Pendir 2 □ Accident investi	ng (Month, igation	. Day, Year)	Injury		k? Yes 2∐N	No					
After dea octor	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	f Injury - At home, fa g, etc. <i>(Specify)</i>	arm, str	eet, factory, office		28f.	Location (Street and N	umber or Ru	ral Route N	lumber,
al or safter if Direction to	Certification: T	4 Homicide	building), etc. (<i>Specity</i>)					City or Tov	vn, State)			
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examination a	e, deat nd/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and th occurred a	due to the at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the caus	e(s)
To th within To the	Me	29b. Signature and title of certifie		111		29c. Licens	e number			29d. Date si	gned (Month	n, Day, Year	.)
		1/2/2	1/1/1	in the	had	D 3	11/61	/		10/	21/00		
7		30. Name and address of person	who completed cause	of death (Item 23a)	(Type,	Print)	100	,			1-1		
			seder III 5				ston.M	D 216	01				
St	tate	31. Date filed (Month, Day, Year,	32/Reč	gistrar's Signature									
Regis	trar	OCT 28	2009 Cet	un B.	136	AND							
DHMH 17 Rev 1	/2001		A		0								

		•	State of Ma State of Ma Registrar		rtment of H		Reg. No	2009	34544
	Physicia		1. Decedent's Name (First, Middle, Last) Ruth R. Pressman			M	ate of Death onth Da		3. Time of Death
-	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		2009 County of Death	19:35 P M
-	Examin	er	WMHS Frostburg Nursing & Re	hah Ctr	Frostbur		Δ	llegany	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Da	ate of Birth fonth, Day, Year,	9. Birth	
ш	Director		234-40-3710 1 M 2 K	81 Yrs.	Working Buyo	04		28 West	Virginia
	pur »	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	f sho	ro	MD Allegany	Frostbu	urg				1 □ Yes 2√□ No
	r 28a- notif	irec	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Cou	ntry?
	th with	Funeral Director	115 Hill Street			21532		USA	
	ems er mu	ner	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify \ an, Mexican, Puerto Rican	res or No- , etc.)	 Race - Ameri Black, White 	
36	within 72 hours affer death with the Maryland ene. Han "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ N If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10 1	1 ☐ Yes 2X No	Specify:		Specify: whi	ite
21215-0036	2 hou atura cal Ex	pel	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation	16b. F	(ind of Business/Ir	ndustry
215	hin 7: e. an "n Medi	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	i+) !		during most of working f)		,	
21	filled wit Hygien other the	Completed		hous	ewife	18. Mother's Name (Firs	t Middle Maide	own home	
Maryland	ntal H ed oth	Be	17. Father's Name (<i>First, Middle, Last</i>) John Lewis Spangler			Ray Amenta			
Z.	should ind Men imarke	ပ္	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rural Ro	ute Number, City	or Town, State, Z	ip Code)
<u>⊠</u>	nd 2 shouth and 27 is me		Donald R. Pressman/spouse	115	Hill Str	eet Frostbu	rg, MD	21532	
<u>6</u>	is 1 and 2 of Health a litem 27 is other trai	1	20a, Method of Disposition	20b. Place of Dispo- cemetery, creft	osition (Name of matory or other place	Date	20c. l	ocation - City or T	Town, State
Ë	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Denation 5 ☐ Other (Specify)						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign ture Filmeral Septire Licenses William 19	ector St	2. Name and Addre tate Anat altimore,	omy Board 65	55 W. Ba	ltimore	Street
			23a. Patt1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	I the death. Do not ent	ter the mode of dyir	ng, such as cardiac or res	piratory arrest,		Approximate Interval Between
-	Physician		Immediate se (Final disease or condition	mscleros	is can	diovascula	n dise	nse	Onset and Death
nine.	/Medical		resulting in death) Due to (or as	a consequence of):					
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	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a concentration of					
ъ.	be executed sician and burial-transit	Examiner	that initiated events c	a consequence of):					
760	eath certificate be ex attending physician for use as the buria	calE	d						
89	tificat ig phy as the				-	-			AT
Вох	th cer endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth	2 Fetal death 3	⊒Ectopic pregnanc	y	į.	23d. Date of del Month	ivery Day Year
	the att	sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	t time of death 5	Other (specify)				•
P.0	hat the	Phy	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tobacci	use contribute to	the cause of death?
ds,	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Completed by Physician/Med					1 🗆 Yes	2	obably 4 Unknown
Sor	v requ been shoul	letec					24a. Was an	24b. Were au	utopsy findings available
Rec	he lav e has ige 2	dmg	-				autopsy performed? 1☐ Yes 2☑	death?	completion of cause of
tal	sician: The la certificate ha rector, page		25. Was case referred to medical			26. Place of Death (Cl			
Z	Attending Physician: r death. ector: After this certifics by the funeral director, t	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatie	ent 3□ DOA Ot	her: 4 Nursing Home	5 Residence	6 ☐Other (Spe	cify)
0 L	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injute (Month, Date of Injute)		Wo		Describe how in	jury occurred	
Siol	endlr eath. or: A	atic	2 Accident investigation]Yes 2□No	Lagation (Ctront	and Number or P	ural Route Number,
Division or Vital Records,	after de	Certification:	Joe Flace of III	jury - At home, farm, st tc. (Specify)	treet, factory, office	281.	City or Town, St	ate)	urai rioute rumber,
L	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	J Ce	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, dea	th occurred at the t	time, date and place, and	due to the cause	e(s) and manner a	s stated.
	ne Hoon n 24 h ne Fur pletely	Medical	(Check only one) Check only one Che	of examination and/or i	investigation, in my	opinion, death occurred	at the time, date	and place, and du	e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		29c. Licen	se number	29d.	Date signed (Moni	th, Day, Year)
			womeethele	MD	Do	655325	C	ct 21, :	2009
			30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)	6 55325 2d cumbol	J MV	21500	_
			WONSOCIC SHTN MD 97 31. Date filed (Month, Day, Year) 32. Regist	trar's Signature	wacsh 1	Cunha	and 11	21306	
	Si Regis	tate trar	OCT 28 2009 Comm	B. gar					

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 27, 2009 5:00 Physician/ Ам Marilyn L. Provenza Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Future Care North Point 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Funeral Days March 2 Months Hours Maryland 1 □ M 2 🗓 F 78 217-26-0718 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21230 USA 1209 Cleveland Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. 3 ₩ Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainments. Elementary/Seconday (0-12) College (1-4 or 5+) Oil Company Clerk 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Margaret Metzger Henry Trow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3832 Homewood Road Cincinnati, Ohio 45227 Robert Risinger, Brother in 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/27/09 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc
299 Frederick Road Baltimore, Maryland 21228 Koma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlyin Cause (Disease or linjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Investigation 6 Could not be Accident within 24 hours after death

To the Funeral Director: ν
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) Signature and title of certifier OCTORER 27,2009 D0060560 address of person who completed cause of death (Item 23a) (Type, Print) 10 V HETERPAL PHILADELPHIA RD 9106 32. Registrar's Signat Date filed (Month, Day, Year) State DOT 2 8 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#5perINF, G898, 12/22/09, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BARBARA B. PAYNE OCTOBER 2009 5:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON GILCHRIST CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 6. Sex Funeral (Month, Day, Year) 8/26/1925 212-76-3914 Months Davs Hours Min 1 🗆 M 2 💢 F Director BERMUDA 84 Usual Residence of Deceder ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No MD BALTIMORE GLEN ARM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21057 BERMUDA 11630 GLEN ARM ROAD APT. 230 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE Specify: 3 X Widowed 4 ☐ Divorced "natural", Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) YEAR Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha OFFICE SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VICTOR DICKENS HAIDEE WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i RAYMOND PAYNE/SON 4330 HALLFIELD MANOR RD. BALTIMORE, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ABurial 2 Cremation 3 Removal from State LAKEVIEW MEM. PARK 10/31/2009 SYKESVILLE, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service V censee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO1139 eath 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INTRAC RANIAL disease or condition CTORER 20, 2009 Medical resulting in death) Due to (or as a consequence of) Examiner MUPERTENSION Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and sthe burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STROKE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy performed? death? 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 164395 OCTOBER 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHARLES ST. SUITE 4105 BALTIMORE, MD 21204 DOBERMAN, MO Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 per MD G896 10/30/09 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Tatyana Cassandra Taylor 2. Date of Death 7 OOG **Physician** PENNA /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ALTIMORE CITY M If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 M 2 F Days Months Hours Director 10 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Examinar must be notified at once. 1 ☐ Yes 2 ▼No Director Owings Mills Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21117 Demel Ct. Apt 3A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gwendolyn Penn ပ Mario Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Demel Ct. Apt 3A, Owings Mills, Md21117 19a. Informant's Name/Relationship (Type. Print) Gwendolyn Penn-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 10/24/09 Woodlawn, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee March Address of Facility 4300 Wabash Ave Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he ift failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 14C4+G 4LMONAM. **Physician** disease or condition resulting in death) /Medical Due to (or as a con squence of): Examiner Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) PNEUMONIA

Due to (or as a consequence of burial-tran resulting in death) Last Box 68760. physician at the burial-Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 No The law requires that the 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed' Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After th funeral 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed tuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

KANTE

DAVID

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Queen Month Physician/ 7000 1725 Octobe Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Baltimore uas blura utheran Nursing 9. Birthplace (State or Foreign 5. Social Security Number If Under 8 Date of Birth Funeral 09/21 19 Country) 1 M 2 X F Months MD 88 217.76.0339 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Raltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 Funeral items 23a Campticla 72 hours after death 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Yes 2 No 1 Never Married 2 Married "natural", or ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced tmerican Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education ral Hygiene. حجا Hygiene. حجا than "r (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) mentary/Seconday (0-12) Maid Hivate tomes should be filed with n and Mental Hygien 7 is marked other th 2th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Andrew Queen permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kandallstown MD 21133 tngela Wilson Court 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 10/31/2009 Woodlawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee f Facility bertu Road Danday Strun MD 21133 23a. Part 1. En er he disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pay Medical Due to (or as a consequence of) Examiner Pava Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Destro for as a consequence of the bunial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled by the funeral director, page 2 should be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4- Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other <u>0</u> 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 S Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical → Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) October 26, 2009 D37573 use of death (Item 23a) (Type, Print) 30. Name and address of person who completed 21136 Main Z, bell MD 2009 32. Rev 31. Date filed (Month, Day, Year) strar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JASON **Physician** RIDLEY-SAVOY Month NICHOLAS 21 09. 10-/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SO.MO. HOSPITAL CENTER MARYLAND PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Yrs Director infant 11 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Prodical Examination of the product of the pro 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No by Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 18) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Specify: 3 Widowed 4 Divorced 1GOK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MICHOUNG homas ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southern Maryland Hospital 7503 Surratts Road Clinton MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 20 23a. art1. Inter the disease, or compiliations that alised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21201 Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Jeve /Medical Due to (or es a consequence of) Examiner Ma Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 C Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No this certificate 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DDA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

7503 SURRA 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 2009

28

DHMH 17 Rev 1/2001

29c. License number

D33268

29d. Date signed (Month, Day, Year)

SALEM I. AL-NABER

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Evantinat risonce.	ete	(Spec	15. Deceder cify only highe					(G	ive kind	t's Usual Occup d of work done NOT use retired	durina m	ost of work	ing	16b	. Kind of B	iusiness/li	ndustry	
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direc		examiner? 1 ☐ Yes 2 🕽	No	Hos	pital: 1 □ Ir	npatient	t 2 🗆	ER/Outpa	atient	3 □ DOA Oti	ner: 4 🗆	Nursing H	ome 5 R	esidenc	e 6 □ O	ther (Spe	cify)	
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Direc in by	Certification: To	4 ☐ Homicide	deter	mined	buildin	ig, etc.	(Specify	y)	, street	, lactory, office				Town, S		iber of the	nai robie rumber,	
		29a. Certifier	Certify	ng Physic	lan: To the	best of	my kno	wledge, d	death o	ccurred at the t	ime, date	e and place	e, and due to	the cau	se(s) and	manner a	s stated.	
ne Fur	Medical	(Check only one)	2☐ Medica	i Examine	r: On the ba and mann	asis of e er state	examina ed.	tion and/o	or inves	stigation, in my	opinion,	death occu	rred at the tir	ne, date	and place	e, and due	to the cause(s)	
To th	ž	29b. Signature and	title of certifi		/					29c. Licen				1	. Date sign	ed (Mont	h, Day, Year)	
		•	110.	IM						25M	140	78457	100 (NJ)	10	122/	109	
		30. Name and add										0 2077 7	.a .o.o	י כם	1750	•		
- CV-		Ravi A. 31. Date filed (Mon					er I 's Signa		e, B	ethesda	a, Ma	aryıa	na 208	721	L / D U			
Stat Registra			2720	09	kenk				Mad									
		7.887.6	B (50		Appendix	-		7										

09-08268

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aymond Reed	R	State of Maryland / Department of Health and No. 1- For State Certificate of Death Registrar		Reg. No	200	9 3455
Physician	1/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day October 24, 20	Year	3. Time of Death 1750 hrs
Medical Examin		Raymond Reed 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc		-	c. County of Death	
, /		1003 South Division Street Salisbury			Wicomico M/DD/YYYY) 9. Bir	tholace (State or
Funeral Director		5. Social Security Number 6. Sex	1.00	Sept 30,	Foreig	ountry) Maryland
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
*	٦	Maryland Wicomico Salisbury				1 Yes 2 No
or 28a-f show	힐	10e. Street and Number 10f. Zip Code			itizen of What Cou	ntry?
nwith the Maryland ms 23a or 28a-f sho be notified at once	프 - 교	1003 South Division Street 21804 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar	nic Origin? (Specif	fy Yes or No-		rican Indian, Black,
r death	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1	Mexican, Puerto Ric	an, etc.)	White, etc. Specify:	nite
ours aft	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation during most of working life. Do	(Give kind of work		. Kind of Business	/Industry
136 thin 72 hours afte ne. than "natural", edical Examiner.	홠	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk	0 140 1 000 100100		Grocery S	Store
5-003 led within Hygiene. other th	Completed		.Mother's Name (Fi		,	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	å	Howard Clinton Reed	Mildred			an Zin Codo)
D 21 should and Me 7 is ma	٩Į	19a. Informant's Name/Relationship (Type, Print) Ralph E. Minder, Cousin 330 Pete Foste:				
e, MD and 2 sho fealth and item 27 is traumati	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemel		Date 20	c. Location - City o	or Town, State
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		Bunal 2 X Cremation 3 Regiloval from State Metro Crematory Inc.	c. 10/2			, Maryland
Baltir permit. J Departm Importa injury o	1	21. Signature of Funeral Service Insee Thomas Gregor Cremation State Service Insee Thomas Gregor 299 Frederic	ociety o	f Maryla	nd, Inc.	and 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su	.CK KOAG I uch as cardiac or re	Baltlmor espiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Medical	- 2	failure. List only one cause on each life. Immediate Cause (Final disease a Severe cardiomegaly and idiopa	athic dil			Death
xaminer	- 1	or condition resulting in death) Due to (or as a consequence of): cardiomyopathy	У			
S.E.	ĕ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
cuted	Ä	d				
68760, certificate be executed nding physician and ise as the burial - transit	Medical	X unpended AMENDED 23a, PII, 27, per ME g897 1	11/20/09	TT	23d. Date of deliv	erv
1876 Tifficate	M/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnance	су	Month	Day Year
Box 6876 The death certificat The attending phed for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown				
D. B. it the de lached is		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	4.6		to the cause of death?
Records, P.O. I The law requires that the cate has been signed by the	d by	Smoking		1 Yes		robably 4 Unknown autopsy findings available
ords w requ	plete			autopsy perform	prior	to completion of cause of
Rec The la	Completed	26 Diago.	of Death (Check or	1 Yes 2	✓ No 1	Yes 2 No
Fital sician: is certification.	Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA	Other		esidence 6 🗸 Of	ther: Scene
of V ng Phy After thi neral d	n: To	27 Magner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury	′ _ I	28d. Describe ho	w injury occurred	
ion ttendir death.	atio	1 X Natural 5 Pending 2 Accident Investigation	es 2 No	39f Location (Str	eet and Number or	Rural Route Number, City
Division of Vital Records, P.O. tat or Attending Physician: The law requires that it as after cleath. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detable.	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office but (Specify)	uliding, etc.	or Town, Sta		Training training on y
Division of Vital Records, P.O. B vithe Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical Ce	Certifying Physician: To the best of my knowledge, death occurred at the time, dail one) Medical Examiner: On the basis of examination and/or investigation, in my opinion,	ite and place, and o	due to the cause(the time, date an	s) and manner as and place, and due t	stated. o the cause(s)
To wit	Mec	and manner stated. 29b. Signature and title of certifier 29c. License		1	October 25, 2	
		Licher Valler Velde O.C.M	VI.E.		October 25, 2	
OV		30: Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, B.	Saltimore, MD 2	21201		
St Regis	ate trar					

DHMH 17 Rev 1/2001 OCME 2006

			For State	State of M	laryland / D	epartmer Certifica			nd Mer			2000	3455
			Registrar 1. Decedent's Name (First, Middle,	Last)			- OI L	Jeani	2	Date of Dea		2009	3. Time of Death
	Physici /Media		GUSTA		REIT	BERGER				Month	Day 2A	Year 2009	1522 M
and.	Examir		4a. Facility Name (If not institution,	give street and number	7)	4b. City	Town, or	Location of D		71-00-	4c. Co	unty of Death	
and a			Jinsi Hospital			1		imare	Cit	4		N/A	
-	Funeral Director		217-82-8810	5. Sex 1 7. A 1 □ M 2 F	ge (In yrs. last birtl 93 Y	8 domethro	r 1 Year Days	If Under 24 Hours	Hrs. 8. Min. 0	Date of Birtl (Month, Day 2 - 10 -	916	9. Birthp Cour	place (State or Foreign POLAND
7	w and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							0d. Inside City Limits
W and	-f sho	to	MD N/A		BALTIMO								1 X Yes 2 □ No
4	r 28a	Funeral Director	10e. Street and Number		1	10f. Zi	p Code				10g. Citizen	of What Cour	ntry?
Ŧ.	23a o	a	3031 FALLSTAFF F	ROAD, #401-	·C	21	209				USA		
₹ 5	ems	nuel	11. Marital Status	12. Was Decedent	t Ever in U.S.	13. Was Dece	dent of H	ispanic Origin n, Mexican, P	n? (Specify	Yes or No-	14.	Race - Americ Black, White,	
になるである 1215-0036 within 72 hours after death with the Manufand	ous auer death with frie Marylar ral", or items 23a or 28a-f show Exardiner mast be notified all	by F	1 ☐ Never Married 2 ☐ Married 3 🗖 Widowed 4 ☐ Divorced	Armed Forces d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1 ☐ Yes		Specify:		,		ecify: WH]	
200	"natural",	sted	15. Decedent's	Education	16a.	Decedent's Usu	al Occup	ation	f warking	- 1	16b. Kind	of Business/In	
Z-Z	giene.	Completed by	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	Give kind of wo life. DO NOT u	ise retired))	working		0.1		
\$ 7 E			8		HOI	<u> 1EMAKER</u>					OWN I		
バケロTBCRGER 〜 らいら Baltimore, Maryland 21215-0036 Permit: Pages 1 and 2 should be filed within 72 hours aft	o • • •	To Be	17. Father's Name (First, Middle, La UNKNOWN	ast)	FUSS			18. Mother's CHAYA	Name (F	irst, Middle,	Maiden Sui	,	(NOWN
ary C	perini: rages I and 2 siloud Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once.</u>	-	19a. Informant's Name/Relationship			Mailing Addres	s (Street a		or Rural R	oute Numbe	r, City or To		
	ealth an 27 l		HENRY REITBERGER	R/SON	(5219 GR	EEN N	1EADOW	WAY,	BALT	IMORE	, MD 21	1209
アクでし limore	Titer or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐ Removal from State		Disposition (Na , crematory or c	me of other plac	e)	Date		20c. Locat	ion - City or To	own, State
i ii	tant:		4 ☐ Donation 5 ☐ Other (Spe	ecify)	ANSHE E	MUNAH A	AITZ	CHAİM	10-2	5-2009	BALT	IMORE,	MD
Balt	Depar Impor any ir		21. Signature of Ameral Service Li	sensee (1 /	22. Name a 8900	nd Addres	SS Of Facility (SOL L WN RO	EVINSO AD, P	ON & I IKESV	BROTHEF ILLE, N	RS, INC. MD 21208
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause only one cause on each	ed the death. Do no	ot enter the mo	de of dyin	g, such as ca	rdiac or re	espiratory ar	rest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	_a. Kulm	onory H	quete	Ci v						Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as	s a consequence of	:):	-						2
	200	Į.	Sequentially list conditions,	b. Tuesto Corn	t block	9							Lyrs.
uted	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,							
60, be executed	physician and the burial-transit		resulting in death) Last	Due to (or as	s a consequence of	j):							
8760,	hysi the I	dical		d									
× 60	attending p	/Mec	IF FEMALE:	000 16 1100 01140000									
Box	atten for us	sian,	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 Fetal death at time of death	3 Ectopic		/			23d	 Date of deliv Month 	ery Day Year
I Records, P.O. Box 6 The law requires that the death certifi	been signed by the should be detached	Physician/Me	1 □Yes 2 □No 9 □ Unknown	9 Unknown		5 Li Other (S	pecily)						
s that	ned b		Part II. Other significant condition	s contributing to death	but not resulting in	the underlying	cause give	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
ords	en siç	ed b							_	1 □ Y	es 2 ☐ N	No 3 Pro	bably 4 Unknown
ecc law re	as be 2 sho	Completed by							_ `	24a. Was a	an 2	24b. Were auto	opsy findings available ompletion of cause of
E Pr		Com								perfor	med? 2 No	death? 1 ☐ Yes	•
/ita	sertific sctor,	Be (25. Was case referred to medical examiner?					26. Place of	Death (C				
of \	After this certificate h funeral director, page		1 Yes 2 No	Hospital: 1 Inpat		patient 3 D		4 LI Nursi				Other (Speci	fy)
ding	h. After funera	tion	27. Manner of Death 1. Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D	jury ay, Year) 28b. Ti Inj	ury M	28c. Injury Work	yat ?? Yes 2□No		. Describe h	ow injury o	ccurred	
Division of Vital Records,	r deat octor: yy the	fica	3 Suicide 6 Could not	t bo	njury - At home, farr			- Z INO		Location (S	Street and N	lumber or Run	al Route Number,
Div	s afte	Certification: To	4 ☐ Homicide determine	building, e	tc. (Specify)					City or Tow	n, State)		
T Hospital	within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical (29a. Certifier (Check only one) (Check only one)	Physician: To the best taminer: On the basis and manner s	of examination and	death occurred or investigation	d at the tir n, in my o	ne, date and pinion, death	place, and occurred	due to the	cause(s) ar date and pla	nd manner as a ace, and due t	stated. o the cause(s)
To the	vithin Fo the comple	Mec	29b. Signature and title of certifier	and manner s	wated,	29	c. License	e number			29d. Date s	signed (Month,	Day, Year)
	7 - 0		> Sando	YIMA			Doc	1027	99		() c to	2	4. 2009
			30. Name and address of person wh	no completed cause of	death (Item 23a) (7			200	£ 0		Vctol timo	J. 0	1,0001
10			Sidney Ne	Ison The Mi	D	Sins	·H	OSIAF	7 of	- B > 1	timo	ve_	
<	Sta		31. Date filed (Month, Day, Year)	Regist	irar's Signature	barlos		1		\			
Y	Registr	बा ।	111.12 (50		- 1- 67								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G896 10/28/09 JH amend item 7 per fh g897 11-6-09 vt State of Maryland / Department of Health and Mental Hygiene Reg. No. 211 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last). Month Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GARDENS ORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 12,25 7. Age (In yrs. last birthday) 1924 6. Sex 5. Social Security Number Days Funeral 1□M 2 F 85 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 2121 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: BLICK, IVN H. 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 If Yes, Give Year or Dates: ٥ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) House Keeper Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21206 Hawkins Dauahter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Hartimore, Marylany 10/29/2009 Crematon 21. Signature of Funeral Service Licenses 22. Name and Address of Acility d M0/55 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ro fremere Dechne **Physician** /Medical Due to (or as a consequence of): Examiner Dement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Pisea Joint Degenratu be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) the 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ pe 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has 1□ Yes 2 9 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. F. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3□ DOA 2140 1 Inpatient 1 ☐ Yes Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death (Month, Day Year, Injury 1 ☑Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/27/09 P31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 821 N. EVTAW MD 21201 ST 8mt 208 BALTIMORE IMHZAH.

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 2000 24 October /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner moria Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 des 2 No 1timore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number , or items 23a or 21218 he Alameda Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Specify Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) New England ndary (0-12) College (1-4or 5+) marked other than 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be 1 fealth and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an permit. Pages 1 at Department of Heah Important: If item any Inline. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO15. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence): 4 yrs Physician disease or condition resulting in death) /Medical Examiner Hmyloidosi marths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2, 2 No 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and Iftle of certifier October 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital 201 E. University Pkwy Baltime State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 22, 2009 Thaxter Swan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friend's Home Sandy Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 A A 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days XXM 2 F 86 109-36-9676 MA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐Yes 2 TNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15401 Bramblewood Drive 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ATyes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired)

Analyst CIA- Federal College (1-4or 5+) Elementary/Secondary (0-12) Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gardner Swan Mary Penhallow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Wintergarden Way; Olney, MD 20832 Lucy Swan, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 10/26/2009 Beltsville, MD 4 Donation 5 Dother (Specify) MD1539 22. Name and Address of Facilit Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Septice License 933 Gist Ave, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Angiosarcoma l year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician as P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes 2 🙀 Hospital or Attending Physician; 25. Was case referred to medical examiner? 8 26. Place of Death (Check ont) one Other: 4—Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1 Yes ZXNo dire ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury nours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 10/24/2009 D18726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Arthur Schoengold, MD 18111 Prince Phillip Drive; Olney, MD 20832

31. Vate filed (Month, Day, Year) State

32. Registrar's Signature

barker

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

1 - State Registra

Physician

1. Decedent's Name (First, Middle, Last)

Box 68760, P.O. Division of Vital Records.

October 21 2009 Alice Elizabeth Schindler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springvale Nursing Center Montgomery Silver Spring Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🗷 F 101 Director Sep 12, 1908 Pennsylvania 178-18-9805 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or items 23a or 28a-f show traumatic event, the Wedical Examiner nust be notified at 1 ☐ Yes 2 X No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 United States Funeral 8505 Springvale Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 2 3 X Widowed 4 ☐ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygier 7 Is marked other th Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington Reichelderfer Bell Filman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Health a permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra Dorothy L Bomberger /Daughter 1540 Live Oak Dr. Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2009 22. Name and Address of Facility Rapp Funeral & Cremation Serv 933 Giet Ave Silver Spring M

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rapp Funeral & Cremation Services 933 Gist Ave Silver Spring Maryland 20910 Approximate Interval Between Onset and Death Immediate Cause (Final Physician BREAS! disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2 12 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation , s after dea..., sral Director: A' filled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10064983 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 MEDIOAC PARK DR #200 Suver Spring MD 20902 KASHIF Alm +IROVZ1 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Day

6:32 PM

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		nent of H cate of L			Jiene leg. No. 20 0	9 34557
	Physici	an	1. Decedent's Name (First, Middle, Las	st)	SHI	2/		2. Date of Deal Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	111 / Maria	4b.	City, Town, or	Location of Death	100	4c. County of D	Death
and a	Funeral		5. Social Security Number 6. S			Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 20 F 72	Yrs.	line Buye		12-9-	- 1436	KOCEH
	Aaryland f show	tor	10a. State 10b. County	DMERV 10c. City,	Town or Location	LNE	V			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-	Funeral Director	10e, Street and Number	PUDDA!	100 10	f. Zip Code		1	10g. Citizen of What	t Country?
	death w	neral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	Decedent of Hi	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian, White, etc.
0030	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If s. M. If all Exs., inc. must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1	es 2 KiNo	Specify:	Tricari, oto.,	Specify:	ASTIAN_
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war)	12 should th and Mer 7 is marke traumatic	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Add	dress (Street a	and Number or Rui	ral Route Numbe	r, City or Town, Sta	te, Zip Code) 20871
J.e			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Placen	ce of Disposition netery, crematory	(Name of or other place	e)	Date	20c. Location - City	or Town, State
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on or	ding Ph n. After th funeral	tion: 1	27. Manner of Death 1/N Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	28b. Time of Injury	28c. injur Worl	yat ⟨? Yes 2 □ No	28d. Describe h	now injury occurred	iOmg
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DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of M	faryland /	Depar Certi	tment of F	lealth and I	Mental Hy	rgien2	009	34558
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Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certifica	been signed by the attending pl should be detached for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth	e of pregnancy 2 Detail deati	h 3DE	ctopic pregnancy	,		23d.	Date of deliv	,
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			31. Date filed (Month, Day; Year)	32 Persis	W. MacPh	nail	Road - S	Suite 106	- Bel	Air, M	arylan	d 21014
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** october 26 Zoc /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** tal lh Ci Mo 9 If Under 1 Year | If Under 24 Hrs Social Security Number (n vrs. last birthday) 8. Date of Bigh (Month, Day, May 25, Birthplace (State or Foreign Country) Funeral 3€3 1 ØM 2 □ F Months Days Hours Director 218-68-5522 70 May 1939 India Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 □Yes 2 No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 'natural", or items 23a 14110 Phoenix Road 21131 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Consulting Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental th Important: If item 27 is marked oth any linjuy or other traumatic event once. Kartar Singh Sidhu Dalip Kaur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 North VanBuren Street; Falls Church, VA 22046 Manpreet Sidhu son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/29/09 Towson, MD DOTHER (Specify) 4 ☐ Donation 1050 York Road 22. Name and Address of Facility 21. Signature of Fun Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one fayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** seandnoal MEON /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the ceath certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p rysiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes 2 🗙 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as success.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) LOO N. Wolfe St. Balkm-re ND21287 M.C 31. Date filed (Month; Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			for State Registrar	tate of Maryland / Depa Cer	artment of Health and M rtificate of Death	lental Hygier Reg. I	ne 2009	34560
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		Robert M. Smith			October 2	0, 2009	11:19 AM ^M
	Examir		4a. Facility Name (If not institution, give street	et and number)	4b. City, Town, or Location of Death		4c. County of Death	
Υ .			7920 14th Avenue		Hyattsville If Under 1 Year If Under 24 Hrs.		Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 1 № M	2□ F 7. Age (In yrs. last birthday) 7 Tyrs. 74 7 Tyrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Mar 18, 1		place (State or Foreign ntry)
	pur M		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	cation		11	0d. Inside City Limits
	f sho	ō	MD Prince Geo					1 □ Yes 2√□ No
	28a-	Director	10e. Street and Number	, -	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	th with 23a or	ral Di	7920 14th Avenue		20783		USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, If a Medical Examplant must be notified at once.	by Funeral	1 Never Married 2 Married	Armed Forces? UIIK 1 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: b1	
1215-0036	vithin 72 housne. She. Shan "natur. Shan "natur."	Completed		mpleted) I (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		Kind of Business/In	dustry un
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Maryland	and 2 should ealth and Mer n 27 is marke er traumatic	오	19a. Informant's Name/Relationship (Type. I Prince George's Pol		ng Address (Street and Number or Run	ral Route Number, Cit	ty or Town, State, Zip	c Code) unk
Baltimore,	Pages 1 ar nent of Hea int: If item : iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 1	oval from State	osition (Name of Inatory or other place)	Date 20c	Location - City or To	own, State
Balti	permit. Departm Importa any inju		21. Signature of Euneral Service Licensee Ronal Communication Was	de, Director St	2. Name and Address of Facility tate Anatomy Board altimore, MD 2120	655 W. Ba	altimore S	Street
100	Physician		3a. Part . Enter the disease, ir complication or heart failure. List only one call immediate cause (Final disease or condition resulting in death)	ns the caused the death. Do not ent ause on each line. Aythevo S		or respiratory arrest,	Pase	Approximate Interval Between Onset and Death
C.	/Medical Examiner	ı		Due to (or as a consequence of): Due to (or as a consequence of):	tension			710 Years
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Prostat	e Cancer			3 Years
8760,	icate be executed physician and the burial-transit	dical E	d	Diabetes M	rellitus			3 Years
O. Box 6	Physician: The law requires that the death certificate has been signed by the attending I this certificate has been signed by the attending I rail director, page 2 should be detached for use as	Physician/Me	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	rery Day Year
rds, P.	quires that in signed build be deta	by	Part II. Other significant conditions contribu	uting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobace	co use contribute to t	the cause of death?
Vital Records,	The law require cate has been signage 2 should b	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
/ita	sician; Th certificate rector, pag	Be (25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)		
of V	hysic this co		1 No Hosp	1 Inpatient 2 EH/Outpatier		ome 5 Aesidence	e 6 ☐ Other (Spec	ify)
n o	ng fter	ü.	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time o Injury	Work?	28d. Describe how in	njury occurred	
Division	or Attend ifter death Director: /	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	an: To the best of my knowledge, deat on the basis of examination and/or in and manner stated.	h occurred at the time, date and place evestigation, in my opinion, death occur	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Comple	Mec	29b. Signature and title of certifier	om, r.p.	29c. License number 0-3 04 27		Date signed (Month,	
			30. Name and address of person who compl	a. Avenue =	#209 , Silve	'V SPY	ing MI	20902
	Sta Registi		31. Date filed (Month, Day, Year) 0CT 28 2009	32. Registrar's Signature	W '			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34561 Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician SMIT 2:43AM OSEPH Octo BER 14 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SECOURS HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1**∑**M 2□ F unk Director 213-76-3141 Apr 28, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1124 N. Monroe Street 21217 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or items unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>6</u> Specify: black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 should be filed with and Mental Hygier 7 Is marked other th unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is n any injury or other traur Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immedi Cause (Final CARDIOVASCULAR DISEASE VIERTENSIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): OBSTRUCTIVE PULMONARY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed that initiated events burial-tra resulting in death) Last Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ∏Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 Tes 2 □NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After the funeral 27. Manner - Death 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

10. April 10. FA B CRUZ M.D BON SECOURS HOSP, TAL

00030355

and manner stated.

2. Registrar's Signature

	4	For St	ate of Maryland	-			Mental Hyo	giene		-1
		Registrar 1. Decedent's Name (First, Middle, Last)		Cert	tificate of D	eaur	2. Date of Dea	Reg. No. 2	009	34562
Physicia		Lillian	Sroka				October	Day	2009	8:55 Рм
Medic Examin		4a. Facility Name (if not institution, give street			4b. City, Town, or I	Location of Death			ty of Death	
		715 Maiden Choice Lan				sville			<u>ltimor</u>	
Funeral Director	1 1	5. Social Security Number 6. Sex 1 M	7. Age (In yrs. las		If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day ADY 1 L _ 2	3,1922	9. Birthp Count Mary	lace (State or Foreign Land
nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10	0d. Inside City Limits
faryla 3a-f s tified	Director	Maryland Baltimore		Catons	sville					1 ☐ Yes 2 No
the Manager 20		10e. Street and Number			10f. Zip Code			10g. Citizen o		try?
hwith ns 23a nust I	Funeral	715 Maiden Choice Lan			21228			US		
baltimore, Maryland ZIZI3-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	1 Never Married 2 Married 1	/as Decedent Ever in U.S. rmed Forces? ☐ Yes 2 ☒ No Yes, Give ear or Dates.	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🔀 No	panic Origin? (S), Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - America ack, White, e fy: Whi	tc.
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thin 7; sne. than he Me	E O		ollege (1-4 or 5+)	life. DC	NOT use retired)	-		Se	lf Emp	oloved
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faryland < 1 should be filed within and Mental Hygiene. is marked other than raumatic event, the Namatic event.		19a. Informant's Name/Relationship (Type, Pr			g Address (Street a					
e, M and 2 s Health a tem 27 i		Ronald C. Sroka, S			Stonegate	e Avenue		1, Mary		
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baltimo permit. Page Department or Important: If in any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ☐ ☐							-	
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		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one cau	ise on each line.				or respiratory an	rest,		Approximate Interval Between
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fou cate be executed physician and the burial-transit	SalE	resulting in death) Last	Due to (or as a conseque	sice oij.						
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S, F.O. ires that the signed by d be detack	ò	Part II. Other significant conditions contribu				en in Part I.				ne cause of death?
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DIVISION tal or Attendir rs after death. al Director: Af ed in by the fu	Certificate:	2 Suicide 6 Could not be	8e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (S City or Tov		nber or Rurai	Route Number,
le Hospita n 24 hours e Funeral	Medical	29a. Certifier 1 Certifying Physician. (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	To the best of my knowled on the basis of examination actioner. To the best of my	and/or invest	tigation, in my opinio	n, death occurred	at the time, date a	and place, and	due to the ca	use(s) and manner stated.
To th To th comp		29b. Signature and title of certifier	0		29c. License			29d. Date sign	ned (Month,	Day, Year)
		Denem Bi	whin	, my	D44	377		101	23/0	9
10 1		30. Name and address of person who comple		23a) (Type, F	Print)	1 10 40	Cata:	C 11 11	0 12	1228
Sta	te	Deneen Bowlin, m 31. Date filed (Month, Day, Year)	32 Registrar's Signatu	den l	and	wine	, Suron	7 11/14	100	<u> </u>
Registr		UCT 88 2003	pour 1	17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 2009 34563 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barbara Catherine Sturgeon Physician/ oct. 19^{ay} 2009 30 PM Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris 4b. City, Town, or Location of Death ${f Towson}$ 4c. County of Death Examiner Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 M 25 F Months Days Hours Min 217-22-9621 84 Director 1925 MD 18. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Dundalk Baltimore MD 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral 18 Kinship Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2x No Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Home Maker Home Be 17. Father's Name *(First, Middle, Last)* Edward Clark 18. Mother's Name (First, Middle, Maiden Surname) Katie Pilarski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18 Kinship Road, Dundalk, MD 21222 Elmer Sturgeon, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cemi10/27/09 Crownsville, MD 22. Name and Address of FacilityWesley Chavis, Jr. FH 21. Signature of Juneral Ser 2007 Eastern Ave. Baltimore, MD 21231 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Dav Pregnant at time of death To the Hospital or Attending Physician: The law requires that the deswithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached to 9 Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Dav. Year) 20 2000 101 ss of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No. 2009 34564 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2009 2:30 SEGALI A M SHIRLEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death KESWICK MULTICARE CENTER BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🖔 F 05-03-1923 Months Days Hours Min. Director 214-18-6957 86 NY Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f 1 Yes 2 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3301 JANELLEN DRIVE 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ,0 Completed by 1 Never Married 2 X Married 2 XNo 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: WHITE Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.

Et if item 27 is marked other than
or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **JACOB** GERTZ SCHUSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILBERT SEGALL/HUSBAND JANELLEN DRIVE. BALTIMORE. MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or BETH TFILOH 4 ☐ Donation 5 ☐ Other (Specify) 10-25-2009 BALTIMORE, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROTHERS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oronar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami sician and bunial-trans that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the buria Physician/Medical a Hospital or Attending Physician: The law requires that the death certificate be set hours after death.
24 hours after death.
a Funeral Director. After this certificate has been signed by the attending physicis a Funeral Director After this certificate has been signed by the cattending set when the letter filled in by the funeral director, page 2 should be detached for use as the bruneleted filled in by the funeral director, page 2 should be detached for use as the bruneleted filled in by the funeral director, page 2 should be detached for use as the bruneleted filled in by the funeral director, page 2 should be detached for use as the bruneleted filled in by the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) Pregnant at time of death 9 Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🐼 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No ဂ္ Kesivic 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural (Month, Day, Year) 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

only one 29b. Signature and title of certific

31. Date filed (Month, Day, OCT 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

6 MD3BG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER **JOSEPH** SILVERMAN 2009 3:10 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death STELLA MARIS TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 08-23-1935 215-32-6381 Director 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗶 Yes 2 🗔 No MD BALTIMORE CITY BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 250 S. PRESIDENT STREET, #902 21202 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian rmed Forces?
X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 5+ College (1-4 or 5+) LAW ATTORNEY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ MOSES SILVERMAN SATISKY BESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN SILVERMAN/WIFE PRESIDENT STREET. #902 BALTIMORE. MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify BALTIMORE. ISRAEL CONG. 10-27-2009 Funeral Service Lice is 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and -transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 2 🗌 No 1 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy perforn 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature

iled (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:25 SCHWARTZ Detaber JUDITH 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1105 Dallingre 19 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Months Hours Min. 218-32-5070 MD 06-23-1936 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ∐Yes 2 X No **Funeral Director** BALTIMORE MD TIMONIUM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 BELMONT FOREST COURT, #201 USA 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 14. Race - American Indian, Black, White, etc. י מועל 2 should be filed within 72 hours after the Health and Mental Hygiene. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be BERNSTEIN FLORENCE SCHNEIDERMAN SIDNEY မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 BELMONT FOREST COURT, #201, TIMONIUM, MD 21093 LEROY SCHWARTZ/HUSBAND 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MENS 4 ☐ Donation 5 ☐ Other (Specify) 10-27-2009 | BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySOL LEVINSON & BROTHERS, INC. Mott (8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Por in the past 12 months? signed by the and be detached for 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy perform certificate 2 Z No ospital or Attending Physician: The hours after death.

uneral Director: After this certificate by filled in by the funeral director, pag 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi

State Registrar 29b. Signature and title of cer

31. Date filed (Month, Day,

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29d. Date signed (Month, Day, Year)

and manner stated.

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30. Name and address of person wo completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 8:09 A Schenker OCTOBER 26, 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. June 1 | 1. J N/A SINAI HOSPITAL 9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number 06-10-1903 106 219-44-5398 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 □ No N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7111 PARK HEIGHTS AVENUE, #803 21215 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 □Yes 2X No If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) SURGEON MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COHEN **SCHENKER** DORA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3504 SOUTHVALE ROAD, BALTIMORE, MD 21208 DONNA SHAPIRO/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ANSPECEMUNAH "ATTZ CHAIM 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 10-27-2009 BALTIMORE, MD 4 Donatten 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Foneral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such es cardiac or respiratory errest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final ha MYOCARDIN INFAMERY disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or es e consequence of)

Year

Day

2 □ No

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner**

Physician

Examiner

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Director MD

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ed other than "natural", or items 23a or 28a-f sho event, the "hotical Even in a mat be notified at

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once.

/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Examiner Physician/Medical ģ Completed Be Certification: To i 24 hours af e Funeral D letely filled ii

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of deeth 3 ☐ Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 **Z** No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Goldson 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Jana 32. Registrar's Signature

DHMH 17 Rev 1/2001

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 **Physician** ĭ ŏ 2009 DAVID THOMPSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HCR Manor Care Potomac Potomac, MD Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 unk **Funeral** 1 → M 2 □ F Months Days 579-84-6291 52 Director 03 21 1957 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ns 23a or 28a-f show must be notified at 1 □Yes 2 □ No Director MD Montgomery Cabin John 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6514 76th Street 20818 Items 23a Funeral USA 14. Race -12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be unk Mary Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manor Care Potomac 10714 Potomac Tennis Lane Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □Donation 5 MOther (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ron 1d 9 Wad 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause Final disease or resulting in death) Physician ENSTAGE rea/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as our results.) Examiner The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🗓 No Ö 9 ☐ Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 1 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 | Inpatient ို this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation neral Director: A 1 Yes 2 No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wisconin AVE #305 8 BIUCNO 8218 Lora 10 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct 19, 2009 Physician/ 11:00 a Raymond Tyler Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 206 South Carey Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov 12, 1937 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 1 F Months Days Hours Min. Director 213-34-9376 Maryland Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Baltimore n/a Maryland 5 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 23a Funeral U.S.A 827 North Arlington Avenue 21217 items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 0 \$ 1 Never Married 2 Married 1 ☐ Yes If Yes, Giv 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", Specify. Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Enterprise Paper & Chemical Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susie Isaac William Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sh Health a 611 Wyeth Street Baltimore, Maryland 21230 Barbara Jones permit. Page 1 and 2
Department of Health
Important: If item 2;
any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/26/09 Lansdowne, Maryland Mt. Zion Cemetery . Signatur Pineral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. / 1300 Eutaw Place Baltimore, Md 21 23a. Part 1. Ofter the disease, or complications that caused shock or heart failure. List only one cause on each tine.

Immediate Cause (Final death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ LUN Metastatic disease or condition Mèdical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Examine Due to for as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events and-trar Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical certificate be Box 68760 attending property for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No that the death Month Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes 2 No 2 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, t 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home . 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide
Homicide

State Registrar

1

Medical

29a. Certifie

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

ns Rajapalise M.D

N. J. Rajapakse, M.D

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0057465

ause or death (ITEM 23a) (Type, Print) 25 Main St. > Suite 200, Reisterstown, MD. 21136

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Leroy 2009 2:05p. 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death Blue Point Nursing Home 6. Sex 1X M 2 D F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Date of Discontinuous (Month, Day, Y 9. Birthplace (State or Foreign Funeral Year) Country) Director 261-46-8800 75 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Directo Baltimore MD NA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A 5621 Belle Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify. If Yes Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 | n and Mental Hygiene. 7 Is marked other than "r Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Julia Jones David Lee Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5621 Belle Ave, Baltimore, Md 21207 19a. Informant's Name/Relationship (Type, Print) Margaret G. Thomas-Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 10/26/09 Owings Mills, Signature of Funeral Service Licensee once. 22. Name and Address of Facility, Tarch F/H West 21215 4300 wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Physician/ Year Atheroscherotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consuluence of burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death detached the Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 24 hours after death.

Funeral Director: After this eleted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 Yes 2 No 5 Pending ☐ Accident ☐ Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one) nd title 29b. Signature 29d. Date signed (Month, Day, Year) DO043375 12009

DHMH 17 Rev 7/2009

State Registrar MATER STREET

32. Registrar's Signature

ETSTERSTOWN, MD 21136

Name and address of person who completed cause of death (Item 23a) (Type, Print)

25

W. MERRITT

KAREN

31. Date filed (Month, Day, Year)

Brock Solomon Tatum Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2009 34571 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 18, 2009 0142 hrs Medical Examiner Brock Solomon Tatum 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 216-19-4069 MĎ Director Jan. 25,198B 1 M 2 F 21 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No 28a-f show Baltimore once. the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 28a-notified at 2408 Guilford Ave. 21218 USA death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Mantal Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2X No Yes Specify: Black Divorced Yes, Give Year Yes 2 No specify: hours after Widowed permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner injury or other traumatic event, the Medical Examiner. \$ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed MD 21215-0036 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginald Hart Bridget Lynn Tatum Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bridget Tatum (Mother) 2408 Guilford ave. Baltimore, MD 21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 10-27-09 Donation 5 Other Specify 22. Name and Address of Facility Wesley Chavis, Jr. FH 21. Signature of Fu, eral Service Licensee 21231 2007 Eastern Ave. Baltimore, MD se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the dis **Physician** Between Onset and failure. List only he cause on each line. Medical Death a. Gunshot Wounds (2) to Head Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown ş Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? ✓ Yes 2 1 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital
To the Hospital or Attending Physician:
within 24 hours after death
To the Finneral Director: After this certif Be Hospital: 1 Other: ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 Inpatient 2 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Oct 18, 2009 Subject shot 0055 hrs Natural Yes 2 V No Pending the Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide or Town, State) 1200 block Hollins Street, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

UHIVIH 17 Rev 1/2001 OCME 2006

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifier

Carol Allan, MD State 31. Date filed (Month, Day Year)

ORIGINAL

Varket

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 18, 2009

1 - For State Registrar

			1 - State Registrar	,	Ce	rtificate of E	Death	R	eg. No.	2009	34572	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year 3. Time of Death			
	Physici /Medic		Maduabuchi Chibuzo		Umegbolu		October	23	2009	3:40 AM		
1	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. Cou	unty of Death			
			Sinai Hospi				if Under 24 Hrs.	0 Data of Birth		0 Birthr	place (State or Foreign	
	Funeral Director		5. Social Security Number 217-41-3765 Usual Residence of Decedent	5. Sex 1 ★ M 2 □ F 7. Age (In yrs. 1 5	Ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	Cour	MD	
Maryland 2121	and		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits	
	Mary f sho	ţō	MD NA Baltimore								1 XYes 2 □ No	
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cour	ntry?	
	3a o	a D	4008 Villa No			21207		U.S.A.				
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		ecify Yes or No-		14. Race - American Indian, Black, White, etc.		
	be filed within 72 hours after death with the Marylan Ital Hygliene. d other than "natural", or items 23a or 28a-f show event, the "Actical Expirition" is set to notified at	by	Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 □Yes 2 No Specify:						Black	
	72 ho	Completed	15. Decedent's	16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry				
	within 7 iene. • than "r	n ple	Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)						
	ed wi ygier her th	ပ္ပြဲ	NA	5	Student			School				
	be fill d off	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
	2 should be n and Mental Is marked of raumatic ev	မ	Sylvanus Umeg	·	T		Eugenia				. 0-1-1	
	h and l l sh	8	19a. Informant's Name/Relationsh			ng Address (Street a						
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	1 6	Eugenia Umegb			B Villa		ad, Ba.		ion - City or To		
	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		1 ☑ Burial 2 ☐ Cremation	3 □ Removal from State St	emetery, cre Cha	osition (Name of matory or other place TIES	9)			,		
	artme ortan injur		4 Donation 5 Other (Sp 21. Sign was if Funeral Service L	DU	rrome	O_Church	n 10/	31/09	Pike	svill	e, Md	
מ	Dep and a series		21. Sign was a Fundament Funeral Service Licensee March and Address of Facility 4300 Wabash Ave, Baltimore, Md 21215									
7	Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List of	complications that caused the deat only one cause on each line.	h. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
			disease or condition resulting in death) a. Congestive Heart Failure Due to (oxas a consequence of):							1 1		
and the												
Division of Vital Records, P.O. Box 68/60		<u>_</u>	Sequentially list conditions,	b. Acute Re						6 days		
		nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4	- andrasian							
	execu and al-tra	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Pulmmany Hypertusim Due to (or as a consequence of): Due to (or as a consequence of): Pown's Sydrone									
	ate be nysician ne buri											
	ng ph ng ph as th	Med										
	ath ce trendi		23b. Was decedent pregnant in the past 12 months?	nancy tal death 3 □ Ectopic pregnancy			23		d. Date of delivery Month Day Year			
	the a	Physician/	1 ☐ Yes 2 ■ No 9 ☐ Unknown	4 ☐ Pregnant at time of o	at time of death 5 🗆 Other (specify)					,		
	sd by detac							bacco use	acco use contribute to the cause of death?			
	signe d be	Completed by	S/P TOF/AV canal repair, acute GI bleed 1 yes 2 No 3 Probably 4 Un							bably 4 Unknown		
	requestion been shoul	ete	prothetic valve placement 24a. Was						an s	24b. Were autopsy findings available		
	has ge 2 a	m	prosmetic valve					autopsy prior performed? performed?		to completion of cause of		
	n: Th ficate r, pag		05 146			1 ☐ Yes 2 ■ No 1 ☐ Yes 2 ☐ No					2 🗆 No	
	sicia certi recto	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	26. Place of Death (Check only one) ent 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
	Phy er this eral d	I inpatient 2 Envougation 3 DOA 4 Nursing nom							28d. Describe how injury occurred			
	th. : Afte	tio	1 Natural 5 Pending 2 Accident investig	(Month, Day, Year)	Injury	Injury Work? M 1 □Yes 2 □No						
	Atter r dea ector	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home			ne, farm, street, factory, office 2			28f. Location (Street and Number or Rural Route Number,			
	al or s afte	Certification:	4 ☐ Homicide determin	building, etc. (opeo.	City or Town, State)							
	Hospit 24 hours Funera etely fille	Medical (29a. Certifier (Check only one) 129a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								stated. to the cause(s)	
	o the	Mec	29b. Signature and title of certifier (Lorio) 29c. License number 29d. Date signed (Month, Day, Year)								, Day, Year)	
	F S F Ö		MD NPT 1235321902 10 (23)09									
	'n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	3		Tessa Payne			lvedere A	ive F	Baltimo	ore 1	MD 2	1215	
	Sta	ata	31. Date filed (Month, Day, Year)	32. Reinstrar's Signa		1 .0				•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar OCT 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2009 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:20194 Alexander 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment us notthed a proce. 1 Yes 2 ☐ No Battiyore Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify ò Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Officer 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Atwater ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raven Blud. Apt. 312 Vaughn Md. 2123 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 D Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera S rv Licensee NO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bucterial Physician one mon 14 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner one week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

68760, The law requires that the death certificate Box (Division of Vital Records, P.O. Hospital or Attending

Baltimore, Maryland 21215-0036

within 24 hours a er death.

To the Funeral Director: A completely filled in by the fu within 24

31. Date filed (Month Day, Year) Registrar

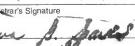
29b. Signature and title of certifier

dress of person who

Ves che 32. Pegistrar's Signature

completed cause of death (Item 23a), Type, Print)

and manner stated.



	4	State of Maryland / [- State Registrar	Department of F Certificate of		, ,	ene 3. No. 2009	21.571
_		Registrar 1. Decedent's Name (First, Middle, Last)	Octimicate of	Deam	2. Date of Death		3 4 5 7 3. Time of Death
Physicia /Medica		Agnes Nan M. Veronica			10/16,	/2009 Year	12:30pm
Examine	r	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital		r Location of Death CKVille		4c. County of Death Montgo	omery
Funeral Director			thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	9. Birth Cou	place (State or Foreign ntry) Scotland
land Dw	-	Usual Residence of Decedent 10c. City, Town 10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
e Mary a-f sho	ctor	OH Jefferson Wi	ntersville				1 ☐ Yes 🏋 No
h with the	Funeral Director	10e. Street and Number 200 Fernwood Road	10f. Zip Code	43953	100	g. Citizen of What Cou USA	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be nothed any once.	by Funer	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 □Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: V	
"natura	Completed by		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work		6b. Kind of Business/Ir	dustry
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ald be file Aental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Alexander W. Smith			e (First, Middle, Ma Bradford		
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oermit. Pages 1 ar Department of Hea mportant: If item : any injury or other		t D Buriel & D Cremetics & M Bernauel from Chate	f Disposition (Name of ry, crematory or other place Calvary Cer	ce) ¦ .		Oc. Location - City or T	
permit. F Departm Importar any Injur		21. Signature of Euneral Service Licensee Victor P. Doda	Charles L. 1501 East				J .
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stages Re Due to (or as a consequence)	enal Disease	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
executed in and ial-transit	dical Examiner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metabolic Ecc. Due to (or as a consequence of the consequence o	tory Failure	9			
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il or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the d in by the funeral director, page 2 should be detached.	Be Completed by	25. Was case referred to medical		26. Place of Deat	24a. Was an autopsy performe 1 □ Yes 24	prior to condend? death? □XNo 1 □ Yes	opsy findings available ompletion of cause of 2 □ No
	0	27. Manner of Death 12 Natural 5 Pending 2 Accident Accident Accident Size Pending (Month, Day, Year)	Oth DOA Oth DOA Oth DOA Oth DOA Oth DOA OTH DOA OTH DOA DOA DOA DOA DOA DOA DOA DOA DOA DOA	4 LI Nursing H	ome 5 ☐ Residen 28d. Describe how	ice 6 Other (Spec v injury occurred	ify)
tal or Atte s after dea al Director ed in by th	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
To the Hospital within 24 hours of the Funeral I completely filled	Medical	29a. Certifier (Check only one) **X**Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.					
To th withir To th comp	Me	29b. Signature and title of certifier	29c, Licens	se number	I	d. Date signed <i>(Month</i> 10/16/2009	, Day, Year)
81	Ī	30. Name and idress of person who completed cause of death (Item 23a) Vinu Ganti, MD 19529 Doctors drive	(Type, Print)				
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature		עבי 20574			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, per FH g896 10.28.09 TT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Day 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 **Physician** 09 E Wharton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Year 218-96-1201 Days Months 1 M 2 □ F 28, 1966 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marital Examinations is an inflied at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Nes 2 No **Funeral Director** altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 7105 Brompton 2120 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Material Handling abore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be njamin ina ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Apt. Brookford 7903 Brown **ON**1 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 09 3 Removal from State 1 Durial 2 ☐ Cremation Baltimore, Hark 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fural Service Lice 22. Name and Address of Facility mD 21207 Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner congestive neer Sequentially list conditions Due to (r as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the ģ s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Ves 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Ch. ck only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Many er of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 🗌 No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifies who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe MO Baltimose EN (Greeke st. power 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Backs

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William F. Wheeler /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours Min. Months Davs 1.X M 2 □ F Director 12/30/21 Maryland 217-18-5361 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Accord Exprinter must be notified an once. 1 XYes 2 No Director <u>Baltimore</u> Md n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3410 Kenyon Avenue 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify ð Specify: 3 ☐ Widowed 4 ☐ Divorced WW II White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bottling Company <u>Truck Driver</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Gossman မ Edwin E. Wheeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janice Johnson / Wife 3410 Kenyon Avenue Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 10/29/09 Baltimore, maryland 4 Donation 5 Dother (Specify) Baltimore Crematory 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Euneral Service Licen 21229 3620 Wilkens Avenue Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or hear failure. List only rie cause on each line. To not enter the mode of wing, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No Dav 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 2 ☐ No 3 ☐ Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA ၉ After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death. within 24 hours after de To the Funeral Directo completely filled in by the

Baltimore,

within 2

5+1 State 29a. Certifier

29b. Signature and tipe of certifier

Medical

and manner stated.

29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560

en Blud Baltimore mo 21239

31. Date filed (Month, Day, 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First_Middle_Last) 2. Date of Death Month Physician /Medical 6:20 PM October 2009 4a. Facility Name (If not institution, give st 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Months Yrs. **Director** None Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Laltimore Funeral Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 10e. Street and Number 10g. Citizen of What Country 21206 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify. Klack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) condary (0-12) College (1-4 or 5+) N/A 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surnar Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important; If item 27 is any injury or other trau Belair Koad 5017 Kalti Hore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 3 Removal from State Greene Cremation Sort Baltimore. mol 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EXTREME PREMATURI **Physician** 2 DAYS disease or condition resulting in death) /Medical **Examiner** 2 DAYS OVER WHELMING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3

Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 🗌 No by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 21 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital: 1 🗷 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 Yes 2 No 2 Accident

Box 68760 P.O. of Vital Records, Division

or Attending death. Funeral Director: Hospital 24 hours

the

Medical State Registrar

KALPASHRI 31. Date filed (Month, Day, Year) OCT 28 2009

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(check only

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RES ODO OCTOBER 19 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

KESAVAN

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity)

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 927AM Physician/ WHEELER Medical Facility Name (if not institution, give street and number) 4c. County of Deat 4b. City, Town, or Location of Death Examiner Union Memorial za ltimone If Under If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 214.50.021 Months Day, Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 XYes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number Funeral USA Stricker 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elemenţary/Seconday (0-12) Church Home Hospital LPN 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) Unik 17. Father's Name (First, Middle, Last) မ Folder Jane Adam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1644 Northbourne Road Baltimore MD 21239 Sandra McCyllough, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 09 Owings Mills, MD 111021 4 Donation 5 Other (Specify) -arrison Vaughor C. Guerre Fursone was 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Pandall Stown MP 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest shock, or hear tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death CardioVascular Disease eroscleration Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Box Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 1 ☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an ate has bage 2 s autopsy death? Yes 2 No 2 1No this certificate 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The control of the desired in the state of the state of the cause of t 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 82 LIAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 23 Physician/ 2009 4:20p M CHARLENE WHITING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE BLUE POINT NURSING & REHAB If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Hours (Month, Day, OCT 12 1 □ M 2 🗓 F ^{Year)} 1952 MARYLAND Director 214-64-2455 57 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director 1XXYes 2 □ No BALTIMORE MARYLAND 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6617 KNOTTWOOD CT. 21214 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1XX Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) HEALTH CARE NURSES AID 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LAURETTA M. HALL REESE WHITING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 6617 Knottwood Ct., Baltimore, Maryland 21214 Cynthia Dixon/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 permit. Page 1 Department of Important: If it cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State injury or LANSDOWNE, MARYLAND MT ZION CEMETERY 10-29-09 4 Donation 5 Qther (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 23a. Part 1. Senter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Betweer Immediate Cause (Final ₽nysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ē Due to (or as a consequence of) Examil sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown nas been signed b e 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 1 Yes 2 No certificate Yes : After this certifications : Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🗷 No Other: 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

only one)

30. Name and

LAREN

filed (Month.

29b. Signature and title of certifier

MERULIT

Registrar

SMITH AVENUE

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

337

KEISTERSTOWN

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Tolbert Ward Melenee Ctober /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmace maryland General XIOSOITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 238-38-4026 Director 82 08 06 SC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, Its Medical Exeminations to a conflict an 1 XYes 2 □ No Director MD NA Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with U.S.A. 21215 5430 Park Heights Ave #114 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Black \$ ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and 2 should be filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 and Mental Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Zion's Cleaners 12th grade 2yrs Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Tolbert Susie Clinkscale 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health Item 27 7400 Dorman Drive, Pikesville, Md 21208 Marechal Echols-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a, Method of Disposition 9 permit, Pages Department of Important: If It any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 10/29/09 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md Kina 21. Signature of Funeral Service Livensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause in each line. 23a. Part 1. Immediate Cause (Final **Physician** umonak disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 mog Year 5 ☐ Other (specify) 1 ☐ Yes 2 🛂 No To the Hospital or Attending Physician: The law requires that the de within 24 hours after death,

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier do 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 40 Hatsa MiR m.1) 31. Date filed (Month, Day, 'Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20c, per FH g896 10/28/09 TT

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 26, 2009 7:36 P WEINSTEIN RACHEI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GILCHRIST HOSPICE CARE Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** POLAND 1 □ M 2 💢 F Months Days Hours Min 01-17-192 **Director** 86 068-44-9638 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD BALTIMORE TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12261 ROUNDWOOD ROAD 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 X Widowed 4 □ Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **HOMEMAKER** OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ NATHAN OLMER RE I SEL HAMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT WEINSTEIN/SON 18 BIRCH LANE, SHREWSBURY. ΜA 01545 20c. Location - City or Town, State **Boynton** 20a. Method of Disposition 20b. Place of Disposition (Name of Date TERNAL LEGET GHT MEMORIAL ☐ Burial 2 ☐ Cremation 3 🗴 Removal from State 10-27-2009 4 Donation 5 Other (Specify) BOYTON BEACH, FL Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) rebrova Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Examine Due to for as a consequency off. cause. Enter Underlying ا 24 hours after death. Puneral Director. After this certificate has been signed by the attending physician and المعالمة المالية الما Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an performed 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 🗌 Yes 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature a 29c, License number 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#20c, perFH, 6896, 10/28/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER WEISS 5:00 P GERTRUDE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDE GENESIS SPA CREEK <u>ANNAPOL</u> 8. Date of Birth (Month, Day, Year) 08-15-1918 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NV 6. Sex **Funeral** Days 1 □ M 2 🗶 F Months Hours NY 91 Director 094-14-7747 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗆 Yes 2 💢 No FL PALM BEACH PALM BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3570 SOUTH OCEAN BLVD., #201 33480 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced WHITE Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOUSEWIFE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည **ABRAHAM** OSMAN KIR<u>SHBAUM</u> LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN WEISS/DAUGHTER 1866 MILVALE ROAD, ANNAPOLIS, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Farmingdale 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 💢 Removal from State MT ARARAT CEMETERY 10-26-2009 **FARMINGOALE** 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & EROTHERS, 21. Signature of Funeral Sarv INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Tiysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Oo Month Day Year Pregnant at time of death be detached 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 00 Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 2 500 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌

State Registrar only one)

31. Date filed (Month, Day, Year)

d title of dertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1) (4

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 24, 2009 2:10 M October Rodger Lee Wratchford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 454 Bonnett Street Aberdeen 8. Date of Birth (Month, Day, You NOV • 16 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) . 1942 West Virginia **Funeral** Days Hours 1**X**1M 2□ F Director 234-64-3736 66 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show XXYes 2 ☐ No Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA Funeral 454 Bonnett Street 21001 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0 1 ☐ Yes 2/ENO Specify. Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Maryland 21215-00; Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturany or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver trucking 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Glen G. Wratchford Sarah Pearl Newbrugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Wratchford (wife) 454 Bonnett Street, Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Old Pine Cemetery 10/29/09 Purgitsville, WV 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lutrace /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician pe Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1□ Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I or Attend after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dimansa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieng 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5-15AM SEHEN 2009 2010 OCT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTINOME 1 ANDALLSTOWN NORTHUEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/11/1926 9. Birthplace (State or Foreign Country) UKRAINE 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 83 218-31-7667 Director Usual Residence of Decedent Manyland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthen "natural", or Iteme 23a or 28a-f ehow tre Medical Examiner must be nutified at 1 ▼ Yes 2 No Completed by Funeral Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 3601 FORDS LANE #319 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filled within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MOVIE WRITER permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: if Item 27 is marked other to eny injury or other traumatic event, ITEM 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN ALEXANDER. ZOLOTAREV YUGENIE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VERA ZOLOTAREVA/WIFE B601 FORDS LANE,#319, BALTIMORE, MD 21215 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK AMUNO 10/25/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHISEAL CANCEIZ Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 40XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No certificate 2 3 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20X No 1 Aspatient 2 2 ☐ ER/Outpatient 3 ☐ DOA After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funaral Direct completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00066357 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATA 12= POIVAMI NORTHWEST 32. Registrar's signature Jako State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G896, IU/28/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 2009 9:05 Barron Peggy Pear1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Williamsport Retirement Center Williamsport If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖾 F 76 236-48-3776 21, 1932 Virginia Oct. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18906 Dover Drive 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Was Decess... Armed Forces? 1 ∐Yes 2 M No Black, White, etc. 1 ☐ Yes 2 № If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No. Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert L. McAtee Matte P. Stump 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald S. Barron/Husband 18906 Dover Drive, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10/22/2009 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

MD

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the "tedical Examinar must be notified at

72 hours after

s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr.

altimore, Maryland 21215-0036

physician and s the burial-trans attending p the detached cate has been signed by page 2 should be detact certificate director, this After this funeral c death. to 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by

P.0.

Division of Vital Records,

25. Was case referred to medical examiner'

1 ☐ Yes

2 Accident 3 ☐ Suicide 4 ☐ Homicide

(Check only one)

29a. Certifier

6 Could not be determined

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

itle of certifie 29b. Signature app

0006323

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21742 580 Northern Ave. Shahid Mahmood

31. Date filed (Month, Day State OCT 28 20 Registrar

Registrar's Signatur

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Bell iv. 09 JAmes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Charle Hospital ivista ha If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-10-1945 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**№** M 2□ F Maryland 217-72-8616 Director 64 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Evanduar must be notified # 1 Nes 2 No Funeral Director Maryland Charles Waldorf 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 221 Barksdale Ave USA 20602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 ☐ Married 2 **X**No Maryland 21215-0036 1 □Yes 2 🛛 No Be Completed by If Yes. Give 3 Widowed 4 Divorced Year or Dates: Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Barber Shop Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Dorothy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Hope Circle, Waldorf Maryland 20601 Theresa Bell/ Sister Baltimore, 20b. Place of Disposition (Name of cemetery (crematory) or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: if ite any injury or oft 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/09 | Alexandria Va letropolitan 21. Signature of Funeral Service Licenses 22. Name and Address of Facility leur 191 Adams Funeral Home PA Aquasco 20608 MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis se, or shock, or heart failure. List complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one use on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): FAILURE Examiner ULMONARI Sequentially list conditions, if any, leading to immediate cause. Enter Unseriging Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 X No 3 Probably 4 Unknown 1 Tyes Be Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, P.O. Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

Registrar

Medical

6 Could not be determined

Year)

3 Suicide

29a. Certifier

4 Homicide

(Check only

31. Date filed (Month, Day,

29b. Signature and title of certifier

29c. License number

1 🖔 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MO

6 EURGE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

KIN5 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34587 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13 2009 Oct. 2:55 PM Aaron Glen Bowman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cecil Port Deposit 775 Principio Rd. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Months Days Hours 71 2, 215-34-5490 Sept. Virginia Director 1938 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show s 23a or 28a-f show 1 ☐ Yes 2 🛛 No Director Maryland Cecil Port Deposit 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 775 Principio Rd. 21904 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 7 is marked other than "natural", or items traumatic event, the Modest Experimental Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after XYes 2 Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced Year or Dates: 1962-64 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 12 Welder Welding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rhoda Evelyn Quisinberry ဂ James Aaron Bowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If item 27 is ury or other trau Dottie E. Bowman/Wife 775 Principio Rd., Port Deposit, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10-18^{ate}2009 permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Colora, Maryland 4 Donation → Other (Specify) West Nottingham Cemetery 22. Name and Address of Facility neral Service License R.T. Foard Funeral Home, P.A. S. Queen St., Rising Sun, 21911 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cenie disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last <u>i</u>e Due to (or as a consequence of): requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ģ 1/ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed The certificate 2. No 1 □Yes 2 1 Tyes director, 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ospital or Attending hours after death. 5 Pending investigation 1 Natural Injury within 24 hours after voc.

To the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Tight Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and maintenance. So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 602 S. Atwood Rd., Bel Air, MDBahrani, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Geneva

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 2009^{ear} **Physician** DCTOBER BRAWNER DENNIS EUGENE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ▼ M 2 □ F Months Days Hours Director 220-26-5915 78 Sept. 2,1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov 27 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Wedical Evan, and out to notified at Brunswick 1√ Yes 2 No Frederick Maryland Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21716 United States 13 West Street 2 should be filed within 72 hours after death in and Mental Hyglene.
is marked other than "natural", or Items 22 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1951-55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>გ</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Railroad Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E11en Cannon Ferris D. Brawner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a 13 West E. Street/ Brunswick Maryland Delores E. Brawner / Wife permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct.6,2009 Brownsville, Maryland Brownsville Ch.Cem. 21. Signature of Funeral Service Licenson 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave./Brunswick, Maryland21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) **Physician** Bladder VROINS caru /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE nse yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ρ 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Yes 2 No P.O. the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 交 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

wil

State Registrar

Sebastien S. Kairouz / 46-B, Thomas Johnson Dr./ Frederick, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-07661 Hope Baldwin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

9

•		I- For State	Certi	ficate of	Death		Re	g. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of Death	1	200 810 hg 458
ledical Exami		Hope Dorine Baldwin					Month October 2,		
7		 Facility Name (if not institution, give street and r 309 Rockwell Terrace 	umber)	41	Frederick, M			4c. County of Frederick	<
Funeral Director		5. Social Security Number 6. Sex 219-66-2550 1 M 2 X F	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24Hr Hours Min			9. Birthplace (State or Foreign Country) 56 Maryland
		Usual Residence of Decedent	75	Yrs.		<u> </u>	Januar	y 20, 17	Journal y Land
any	ı	10a. State 10b. County	1	own or Locatio	on				10d. Inside City Limits
daryland 28a-f show any 1 at once,	ᅵ	Maryland Frederick	Fred	erick					1 X Yes 2 No
Aaryla 28a-f	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
th the Maryland 23a or 28a-f sho		309 Rockwell Terrace			21701			USA	
th with	uneral		ecedent Ever in U.S. Forces?		Decedent of Hisp s, specify Cuban,		Specify Yes or No- o Rican, etc.)	14. Race White	- American Indian, Black, e, etc.
er dear	ш	1 Yes 3 Widowed 4 Divorced If Yes, Give Y	2 X No		Yes 2 X No	specify:		Specify:	white
urs aft tural"	d b	15. Decedent's Education (Specify only highest gr		16a. Decedent	's Usual Occupation	on (Give kind of		16b. Kind of Bus	
21215-0036 Id be filed within 72 hou fental Hygiene. narked other than "nat event, the Medical Exa	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)	during mo	st of working life.	DO NOT use re	tired)		
036 vithin 72 ene.	립	12		cafete	eria wo			food se	
Hygi d other	ပ္တို	17. Father's Name (First, Middle, Last)			1		ne (First, Middle, N)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	William Henry Baldwin 19a. Informant's Name/Relationship (Type, Print)		19b Mailing	Address (Street		n Anna Kı		n, State, Zip Code)
MD 21215-0036 of 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho anmatic event, the Medical Examiner must be notified at once		Faith Carpenter - siste	er						yland 21702
e, N 1 and Health Item	- 1	20a. Method of Disposition		ace of Dispositematory or oth	tion (Name of cem	netery,	Date	20c. Location -	City or Town, State
more, N Pages I and ient of Healt int: If item		Burial 2 X Cremation 3 Removal 4 Dogation 5 Other Specify:			Crematory	y 10	0-6-2009	Freder	cick, Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Fleatht and Mental Hygiene. Important: If Item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee	1/1-	22. Na	ame and Address	of Facility S	tauffer	Funeral	Home
@ 52 5 1		Sharow Canvil	e Clea						Maryland
Physician /Medical		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.			e mode of dying,	such as cardiac	or respiratory arm	est, shock, or hea	art Approximate Interval Between Onset and Death
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		h Chronic A							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	a consequence of):						
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OX 687 eath certific	ician/	past 12 months?	birth gnant at time of dea	44	aldeath 3 ner (Specify)	Ectopic preg	папсу	Worter	Day Year
Box e death c the atten	hysi	1 Yes 2 V No 9 Unknown g Unk	nown						
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ords, P.C w requires that is been signed t				<u> </u>			- [24a. Was		Were autopsy findings available
cord law req has bee	plet						autop	osy t	prior to completion of cause of death?
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should I	Completed	<u> </u>					1 ✔ Yes		Yes 2 No
of Vital Recting Physician: The After this certificate funeral director, page	Be	25. Was case referred to medical examiner?	1			of Death (Chec		Desidence of	- Cultura Consta
of Vi ing Physi After this uneral dir	ပ္	1 ✓ Yes 2 No		ER/Outpatient 28b. Time of Ir		ry at Work?		Residence 6 how injury occurr	
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risior r Attend er death irector:	ficat	2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At hor	me, farm, stree	et, factory, office b	uilding, etc.			per or Rural Route Number, City
Divisi Hospital or Ati 24 hours after d Funeral Direct	Certification:	Suicide 6 Could not be determined (Special	y)				or Town, S	State)	
Hos 24 h Fin tely		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge	e, death occur	red at the time, da	ate and place, a	nd due to the cau	se(s) and manne	er as stated.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the bas and manne	s of examination an r stated.	d/or investigat			at the time, date		
	Σ	29b. Signature and title of certifier			29c. Licens O.C.I			October 2,	ned (Month, Day, Year)
		(actions)	nune of death /lt-	23.0\	0.0.1			00:000: 2,	,
3		30. Name an laddress of person who complited on Laron Locke MD. Assistant Medi			Street, Baltin	nore, MD 2	1201		
S	tate		Registrar's Signatur	e f	ented				
Regis	trar	001 0 1 2003	Claud,	a. Alex					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009

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		•	1 - State Registrar			Cer	tificate of	Death		Re	g. No.	200	7	3435
	Discussion.		1. Decedent's Name (First, Middle,							Date of Deat Month	n Day	Year	3. Time	of Death
44.	Physici /Medic		Frances Z	Brown						Octobe		PUUS	100	(5 AM
	Examir		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location	of Death		4c. Cou	inty of Death		
7			Sanctuary at Holy (Irtons				Montgo		
Г	Funeral			5. Sex 7. Ago 1 ☐ M 2 🕱 F	e (In yrs. last bir	thday) L Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day,		Coun	itry)	e or Foreign
	Director		201-01-6111 Usual Residence of Decedent		90],	June 18,	TATA	Penn	sylvan	1a
	land ow		10a. State 10b. County		10c. City, Tow	n or Loc	cation					1	0d. Inside	City Limits
	Mary Fled	ţo	Maryland Monts	gomery				Ashtor	1				1 □ Ye	es 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10	Og. Citizen	of What Coun	itry?	
	th wit 23a o Ist be		1409 Patus	ent Drive				208	361			U.S.	.A.	
	ems er mi	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of I	Hispanic O	rigin? (Spe ın, Puerto I	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Me. Ical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🗷 l If Yes, Give Year or Dates:	No	1	☐ Yes 2 No	Specify	:		Spi	ecify:	White	e
5-0	72 ho	etec	15. Decedent's (Specify only highest	Education grade completed)	16a	(Give I	ent's Usual Occup kind of work done	during mo	st of workit	ng	16b. Kind o	of Business/Ind	dustry	
21	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	OO NOT use retire					0 1	-101	
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and	should be filed nd Mental Hygi marked other matic event, ti	Be	, , , , , , , , , , , , , , , , , , , ,	,				TO, IVIOLI	iei s ivailie	,		name)		
ž	hould d Me nark natic	P.	19a. Informant's Name/Relationshi	t Crotzer	101	Mailin	g Address (Street	and Numl	oor or Rura	Susan Bo		wn State Zir	Code	
Maryland	d 2 s th an 7 Is r traur		Thomas W. Hamilton		130)9 Patuxent				-		ooue,	
	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic ex once.		20a. Method of Disposition	- 30H	20b. Place o	f Dispos	sition (Name of	i				on - City or To	wn, State	
altimore,	Pages nent of I ant: If its ary or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natorý or other pla ven Cemete		10/16	/2009	Ci lua	r Spring	Mars	zland
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B	permi Depar Impor any Ir) ala	1 Dan	٥٥٥	F	lines-Rina: 11800 New I	ldi Fu Jamoshi	neral I	Home, Inc.	ver Spi	cing. Mar	cvland	20904
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<u>α</u>	requires that the een signed by the	/ Ph	Part II. Other significant condition	s contributing to death b	ut not resulting i	n the ur	nderlying cause gi	ven in Part	l.	23e. Did tol	acco use	contribute to tl	ne cause c	of death?
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000	w rec	Completed by	Presumed Inf	ected Righ	A 14.0	Po	usthesis			24a. Was a	n 2	4b. Were auto	psy finding	gs available
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>	ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/O	utpatien	t 3 DOA Ot	har		me 5 □ Reside		Other (Special		
ō	g Ph ter th neral		27. Manner of Death	28a. Date of Inju		Time of Injury	28c. Inju	iry at		28d. Describe ho	w injury o	ccurred		
<u>0</u>	ath. or: Af	atio	1, SNatural 5 Pending 2 Accident investiga	tion	, , , , ,	,,		Yes 2]No					
Division or Vital Records,	after death. I Director: After this certificd in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin	20e, Flace Utilij	ury - At home, fa c. (Specify)	arm, stre	eet, factory, office		1	28f. Location (Si City or Town	reet and N n, State)	umber or Rura	al Route N	umber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C		Physician: To the best xaminer: On the basis o and manner st	of examination as									e(s)
	omple	Med	29b. Signature and title of certifier				29c. Licen	se number		2	9d. Date s	igned (Month,	Day, Year	-)
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	1		30. Name and address of per on w	ho completed cause of c	leath (Item 23a)	(Type.								
			Dowtly Sera		5 Mais		neet Su	ute ?	Less T	Reisters	town	Md.	21134	7
	Sta	ate	31. Date filed (Month, Day, Year)	Registr			wi	- / -						
	Regist	rar	OCT 1.5 2	009 Centra	1 1. 1	par								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:02 am Celestine W. Bennett October 08, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital 01nev 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🕱 F Director 78 April 10, 1931 Pennsylvania 203-24-1573 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐Yes 2 X No Director Maryland Montgomery Silver Spring 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 13818 Town Line Road 20906 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify 2 Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland State Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Pages 1 and 2 should be Samuel Womack Sadie Killin other traumatic 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Bennett - Husband 13818 Town Line Road, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or or 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 10/15/2009 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Otherosclerke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 🗆 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours a within 2

Baltimore, Maryland 21215-0036

10

Registrar

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 2. Registrar's Signature

Moderal Director

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 050410

Olney

29d. Date signed (Month, Day, Year)

10/9/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene 2 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:13 PM tober <u>Vivian Castello</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Medical a Plata Charles (onter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Vear) Months Days Hours 1 □ M 2 🕱 F October 30, 1923 Texas Director 467-24-1221 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, It e five fice! Examiner must be notified at 1 □ Yes 2 X No Funeral Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12821 Simpson Drive 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 □Yes 2 No Specify White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government <u>Budget Analyst</u> 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ို Roy Hughs Virtle Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 3958 Northgate Pl. Waldorf, Maryland, 20602
sition (Name of Date 20c. Location - City or Town, State Bobby Jo. Renaudtash/ Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens | Oct. 16, 2009 Waldorf, Maryland 21. Signature of Foreral Service Licens, e 22. Name and Address of Facility Huntt Funeral Home 903035 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischeme **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) been signed by the should be detached Ö 9 □ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Phys. Ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exam r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 109 D 33426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

LARRY B. JENKINS, JR., M.D.

1 4 2009

31. Date filed (Month, Day, Year)

barke

32. Registrar's Signature

III LAGRINGE AVE, LAPLATA MD 20646

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DB2 / (TIZO YCM2/+ WAT HEN M. V. WALDORG-MIL ZOLT	,			30. Name and address of pers	son who completed cause of	death (Item 23a) (Type,	Printly	7.01		0 0 0				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 34594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 10 Day 2009 Year Harriet Wooding Cropper 8:20 am^M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yes 4/8/1959 Birthplace (State or Foreign Country) 6. Sex (In yrs. last birthday) Days Hours Min. 1 □ M 2 □ X F 50 230-04-5513 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TX No Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6955 Quantico Rd. 21830 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. Phone Cards of Delmarva 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Haraway Hazel Wooding 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Cropper / husband 6955 Quantic Rd., Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Cape Henlopen Crem 10/14/2009 | Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rosepsi disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nero sclerosis 3 √ robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Lardiumy opath u 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA i≱Yes 2 □ No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

551 230-04o. Records, **Division of Vital**

burial-trar detached Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "maldal Evantinal must be notified at

ould be filed within Mental Hygiene.

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permit. Pages 1 and 2 s
Department of Health as
Important; If Item 27 is
any Injury or other trauonce.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Be Completed

29a. Certifier (Check only one)

Baltimore, Maryland 21215-0036

Funeral

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Completed

Be

Medical Certification: To To the

ET 10 State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Szymala Justan 31. Date filed (Month, Day, Year)

OCT 1 4 2009

29b. Signature and title of certifier

Atlantic General Hospital 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 164428

Healthney Drive 9733 Berlin MD 21811

29d. Date signed (Month, Day, Year)

Registrar

parke

			1 - State Registrar		Ce	ertificate	of Death	7	F	Reg. No. 2 U	09	34595
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	ooper, Jr.					2. Date of Dea Month	Day	Year	3. Time of Death
The state of the s	Examin		4a. Facility Name (If not institution, give: Arne Armael M	street and number)	~		n, or Location	-		4c. County		ndel
	Funeral Director		5. Social Security Number 6. Sex 128–26–6327	x 7. Age (In yrs. Ia M 2□ F 76	ast birthday Yrs.	y) If Under 1 Y Months D	ear If Unde ays Hours	Min.	8. Date of Birth (Month, Day Feb. 28	Year)		place (State or Foreign
	show show	٥٢	Usual Residence of Decedent 10a. State 10b. County MD Anne Ar		, Town or L Annap						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith the M s or 28a-f be rotiffs	Direct	10e. Street and Number 104 Summers Run	didei		10f. Zip Co	de 2140			10g. Citizen of V	hat Cour	ntry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm I redical Exemplear must be notified at once.	by Funeral Director		12. Was Decedent Ever in U.S Armed Forces? 1 ⊠Yes 2 □ No 195	5. 13	B. Was Decedent If Yes, specify			cify Yes or No- Rican, etc.)	14. Rac Blac		can Indian,
21215-0036	2 hours af atural", or cal Exami	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	If Yes, Give Year or Dates: 197	7 16a. Dec	1 ∐Yes 2 🗽 cedent's Usual C	ccupation			Specify 16b. Kind of Bu		uite dustry
21215	d within 72 giene. er than "n	Completed	(Specify only highest grade	completed) College (1-4or 5+) 5+		ve kind of work d . DO NOT use n nopedic/				Medic	cal	
Maryland	uld be filed Mental Hy rked othe	To Be (17. Father's Name (First, Middle, Last) Neill Stewart Coop	per, Sr.					(First, Middle, avia Hov	Maiden Surnam W es	e)	
, Mar)	ts 1 and 2 shoild the strain of Health and I them 27 is main other trauma		19a. Informant's Name/Relationship (Ty, Virginia Mae Coope			iling Address <i>(Si</i>				r, City or Town, MD 214(Code)
Baltimore,	Pages 1: ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	metery, cri	position (Name of ematory or other cremator	place)	Oct. 2009	7,	20c. Location -		
Balt	permit. Departi		21. Signature of Funeral Service License	ee Vu		22. Name and A Barranc 495 Gov	o & Soi	ns. P.	A. Sev	verna Pa	ırk F	uneral Home MD 21146
4	Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. ne cause on each line. a	e hea	_		as cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
.2	Examiner	ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence).								
90,		ш	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):							
(68760,	ertificate ing physi e as the b	Medical	IF FEMALE:	d								
. Bo	death c e attend d for us	by Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	B ☐ Ectopic preg □ Other (speci				23d. Dat Mo	e of deliventh	ery Day Year
	v requires that the de been signed by the should be detached	ed by PI	Part II. Other significant conditions cor	ntributing to death but not result	Iting in the	underlying caus	e given in Parl	: 1.	23e. Did to			he cause of death? cably 4 ☐ Unknown
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed							24a. Was a autopo perfor	sy per med?	Vere auto prior to co leath? ☐ Yes	psy findings available impletion of cause of 2 No
=======================================	Ician Sertiff ector	Be	25. Was case referred to medical examiner?	loonital:				ce of Death	(Check only or	ne)		
ō	Phys r this c	2	I les 2 pou	lospital: 1 ■Inpatient 2 □ E						ence 6 □ Oth		fy)
sion (ttending F death. tor: After the funera	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Year)	28b. Time Injury	М	Injury at Work? 1 □Yes 2 □		8d. Describe h	ow injury occurr	ed	
DIV	or A ifter (Direction by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,)				City or Tow	n, State)	,	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examli one)	sician: To the best of my know ner: On the basis of examinati and manner stated.		investigation, in	my opinion, d	eath occurre	ed at the time, o	date and place,	and due to	o the cause(s)
	o ₹ o 5	2	29b. Signature and title of certifier			29c. Li	cense number		2	29d. Date signed	(Month,	Day, Year)

10/6/2009

34595

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ivelisse Michel Parkway, Annapolis, MD 2001 Medical

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 09 2009



D69 566

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State C	f Maryland / Dep <i>Ce</i>	artment of F			iene eg. No. 20	09	3459	7
	-	13	Decedent's Name (First, Middle, Last)				2. Date of Death	h	'ear	3. Time of Death	_
	Physici /Medic		Mamie B.			Diggs	10-7-		ear	11 am ^M	
4	Examir		4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, o	r Location of Death	1	4c. County of	Death		
À			Genesis Home		Wald	orf		Char	les		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) (Birthpla Count	ace (State or Foreign	
ы	Director		218-20-1559 ^{1□M 2} ² ³ F	88 Yrs.	I ayo		4/2/19		Mary	land	
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10	d. Inside City Limits	_
	anyla shov	<u> </u>		~					'	1 ☐¥es 2 ☐ No	
	he M 8a-f	Director	Maryland Prince Geor	ge Suitl			14	Og. Citizen of Wh	ot Count		_
	with t		10e. Street and Number		10f. Zip Code	0746	11			.y.	
	s 23	Funeral	5526 Hartfield Ave	edent Ever in U.S. 13.		0746	necify Yes or No-	14. Race -		n Indian.	_
	item item	Ë	Armed Fo	orces?	Was Decedent of H If Yes, specify Cub	an, Mexican, Puerl	o Rican, etc.)		White, e		
36	ırs af I'', or xami	by F	If Yes, Gi 3 ☑ Widowed 4 ☐ Divorced Year or D	ve	1 ☐ Yes 2 🛣 No	Specify:		Specify:	Bla	ck	
Ş	2 hou	be	15. Decedent's Education	16a. Dece	edent's Usual Occup	pation	1	16b. Kind of Busi			
75	nin 72 In "n Medii	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give	e kind of work done DO NOT use retire	during most of woi d)	rking				
2	d with giene rr tha the l	Completed	12		omemake:	r		Do	omes	tic	
Þ	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, M	Aaiden Surname))		
Baltimore, Maryland 21215-0036	ould be filed within 72 hours after death with the Manyland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at	10 E	Benjamin	Henso	n	Annie			Mon	roe	
=	E E E		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street	and Number or Ri	ıral Route Number	City or Town, S	tate, Zip	Code)	
Σ	and 2 ealth a n 27 is er trau		Doris Brown/ Daugh		Hartfi						
Se	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other pla	ce)	Date	20c. Location - C	ity or To	vn, State	
Ĕ	Pag nent ant: I		4 □ Donation 5 □ Other (Specify)	St.Thom	as Ch.C	em 10/	14/09 1	Brandyw	vine	MD	
at	permit. Departr Importa any Inj		21. Signature of Funeral Service Licensee	2	22. Name and Addre	ess of Facility					
<u> </u>	9 9 E 6 9	91	Tells 7		Adams Fi				O M		
п			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	caused the death. Do not er each line.	nter the mode of dyi	ng, such as cardia	c or respiratory arre	est,	17.7	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	IN STAGE	DEN	IENTI.	4			Offset and Death	
	/Medical		resulting in death)	(or as a consequence of):		100111	/				
	Examiner		Sequentially list conditions, b.								
3.	D #	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):							
	ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last						-		
30,	ate be executed obysician and the burial-transit	ı E	Due to	(or as a consequence of):							
8760,	icate be executed physician and s the burial-transit	dical	d								_
9 ×	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	toomo of prognancy				001.0			
Box	ath c	ian/	in the past 12 months?		□Ectopic pregnanc	у		23d. Date Mont		ry Day Year	
0	the a	/sic	1 ☐ Yes 2 ☑ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unknown		Other (specify) _						
P.O.	hat the		Part II. Other significant conditions contributing to d	eath but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	acco use contrib	oute to th	e cause of death?	_
S,	ires t signe d be c	by	Commence As an	DED PUE	EIM DAI	4	1 🗆 Y	es 2∐No 3	B ☐ Prob	ably 4 Unknown	
Ö	requ	etec	COMMON II II	11-12-17-17	13,000	<i></i>	04. 111.	0.41-144			
3ec	has b	Completed					24a. Was a autops	sy pr	ere auto ior to cor eath?	osy findings available npletion of cause of	
<u>=</u>	cate page	වි					1□ Yes	med? de 2 No 1 I		2□ No	_
VIII:	ician sertifi ector	Be	25. Was case referred to medical examiner?	0,000,000,000	Lou		ath (Check only on				
or	Phys this a	은	1 10 100	Inpatient 2 ☐ ER/Outpatien of Injury 28b. Time	BUIL 3 DOA	4 Nursing I	Home 5 ☐ Reside			")	_
E C	ling I After uner	inol in	Tanvatural Old Citating	oth, Day Year) lnjury	Wo	rk?]Yes 2∐No	260. Describe in	ow injury occurre	u		
Division or Vital Records,	ttend leath stor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Plac	of injury - At home farm s		jtes 2∐NO	28f Location (S)	treet and Numbe	r or Rura	l Route Number	
<u> </u>	or Ai	Ę	4 Homicide determined build	e of injury - At home, farm, s ling, etc. <i>(Specify)</i>	meet, factory, office		City or Town	n, State)	or riura	Troute rumber,	
	pital ours a eral I		29a. Certifier 1 Certifying Physician: To th	e best of my knowledge des	ath occurred at the t	ime date and place	e, and due to the o	ause(s) and man	iner as si	ated.	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: On the								
	o the ithin o the omple	Me	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)	_
	⊢ ≯ ⊢ ŏ				a i	1601		10-7	-0	9	
			30. Name and address of person who completed cau	se of death (Item 22a) (Time	Print)	4,00		/	,		_
	83		50. Iyame and address of person who completed cau	12/17/1 /// // ///	line Pan	ter Wa	IdNF Mil	MILLAN	1		
	Sta	ate	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	Jine Cu.	10 101	/ 1010	71410			_
	Regist		nct 132009 /	Survey A 1	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0:27 4 M **Physician** 09 onothi 0 5195 /Medical 4c. County of Death 4b. City. Town, or Location of Deatl 4a. Facility Name (If not institution, give street and number) **Examiner** Montg omery has hington Acluentist AKOMA 9 Birthplace (State or Foreign Country) 5. Social Security Number If Unde Date of Birth (Month, Day, 6. Sex Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗹 Yrs. Maryland 68 213-40-5958 - 15 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural" or items 23a or 28a-f show traumatic event, the Pedical Evenings must be notified at 1 ☐Yes 2 ☐ No Directo Marzyland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20608 16901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 □No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen. Important: If them 27 is marked other the any injury or other traumatic event. It all Operator irect 12 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be MAIR ၉ harles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Y MI 20608 tacle ٥ 16901 SAMbe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer S rvice Licen Name and Address of Facility 22 20608 44AM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARTHOROSCLIPATIC DISEASE Immediate Cause (Final HEART **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PRILIPA RENAL FNO STAGE Secue tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed PALLURA CONGESTIVE HEART and Due to (or as a consequence of): aftending physician of for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 **N**C □Yes ned by the P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 48083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

WESTMON

132009

IRVINE

31. Date filed (Month, Day, Year)

TAKOMA

20912

CASTOI

32. Registrar's Signature

1600

09-08021

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 34599

lary	Deneil	1-	For State Control of Treath and T	Reg. N		0 5 5 4 5 5
	Physicia		eqistrar 2. Dacedent's Name (First, Middle,Last)	ate of Death	v Year	3. Time of Death 1806 hrs
/lec	dical Examin	er	Mary E. Denell Oc	tober 15, 2	009 4c. County of Death	
(4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2654 Singleton Terrace Frederick		Frederick	
		4		Date of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or
	Funeral Director		214-70-1049 1 Months Days Hours Min. 30	uly 17	, 1956 Co	ountry)Maryland
	b		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ow any		Maryland Frederick Frederick			1 Yes 2 X No
	Maryland 28a-f show d at once.	ōΙ	10e. Street and Number	10g.	Citizen of What Cou	
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f sho nother traumatic event, the Medical Examiner must be notified at once.		3651 Singleton Terrace 21704			d States
1	n with	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Library Specify Cuban, Mexican, Puerto Rica	Yes or No- in, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
-	r death or ite	Funeral	Never married 2 mainled 1 Yes 2 No		Specify: W	hite
2	irs afte	٦	To Dates. 15 The state of the party of the p	done 16	b. Kind of Business	/Industry
	72 hou n "nat	Completed	15. Decedent's Education (Specify only highest grade completely) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	ļ		_
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	直	12 Homemaker 18. Mother's Name (First	st. Middle, Mai	Own den Surname)	Home
	15-C		17. Father's Name (First, Middle, Last) 18. Mother's Name (First			
	2121 uld be fi Mental I marked	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Numbe	r, City or Town, Sta	te, Zip Code)
	MD nd 2 sho alth and m 27 is aumati	- 1	Diana Selego / Daughter 21015 4th Street, Lan o	Lakes	FL 3463	8 or Town, State
	Fe, S 1 and f Heal		20a. Method of Disposition crematory or other place)	ľ		
	Page ment o tant: or oth		4 Donation 5 Other Specify: Stauffer Crematory 10/21		<u>Frederic</u> er Funera	k, Maryland
	Baltimore, MD 21215 permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked or injury or other traumatic event, th	-	1621 Opossumtown	Pike.	Frederick	
	Physician	-/	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resfailure. List only one cause on each line.	spiratory arrest	, shock, or heart	Approximate Interval Between Onset and
m	'Medical	٩	Immediate Cause (Final disease or condition resulting in death) a. Complications of chronic alcohol use a Due to (or as a consequence of):	nd acu	te	Death
٠.	aminer		or condition resulting in death) Due to (or as a consequence of): ALCOHOL INLOXICALION			
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
Þ		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-		
	uted nd ransit		d			
	cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and as 2 should be detached for use as the burial - transit	Medical	X AMENDED #8 per Int g896 10/30/09 TT 23a,27,28a-f,permE, g897 11/4/0	09 TT	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	760, icate be g physic the burn		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	у	23d. Date of deliving Month	Day Year
	Box 687 e death certific the attending p	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
	Bo: te deat the at the at	Physician/	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
	P.O. es that the igned by be detack	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	2 🗸 No 3 📗 F	Probably 4 Unknown
	ds, lequires	eted		24a. Was au		e autopsy findings available to completion of cause of
	COF	Completed		perform	ned? deatl	n?
	tal Rec		25. Was case referred to medical 26.Place of Death (Check on			- Face-time
	Vital F hysician: this certifi	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing I		Residence 6 🗸 0	ther: Scene
	on of tending Pheath. or: After the funeral	T: T	27. Manner of Death (Month, Day, Year)	8d. Describe n 1 nk	ow injury occurred	
	Sion Attend death ctor:	atic	Pending 10/15/00 Pd 6.00 pm	-	treet and Number o	r Rural Route Number, City
	Division of Vital Records, rat or Attending Physician: The law requir as fare death. an Director: After this certificate has been s led in by the funeral director, page 2 should 1	Certification:	3 Suicide 6 X Could not be determined (Specify) found at residence	rederic	k, MD	r Rural Route Number, City ingleton Ter.
	Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Hospital Director: After this certificate has been signed by the attending physici prompletely filled in by the funeral director, page 2 should be detached for use as the buri		4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and discharge of the control of the	ue to the cause	e(s) and manner as	stated. to the cause(s)
	Fo the within Fo the comple	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and of (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated. 29c. Circular and title of certifier.	a.o amo, date e		(Month, Day, Year)
Y		2	29b. Signature and title of certifier O.C.M.E.		October 16, 2	
1			30. Name and address of person who completed cause of death (Item 23a)			
()		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
	Regi:	tate	111 1 12 2 7 1111U 1 76 28 26 26 27			
	المندو					

Certificate of Death

Reg. No.

1:20 P M

1√2 Yes 2 No

Year

Frederick My 21702

941

State Registrar

31. Date filed (Month, Day, Year)

1 - For State Registrar

arke

32. Registrar's Signature

2009 ▶

09-08019 Mehki Doe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

19 Doe		Please Type or Print in Black Indelible Ink. State of Maryland / Department of Hea	alth and Mental Hyg	giene	2000 21.00
		or State Critificate of Dea	ath	Reg. No.	2009 3460
Physician/ al Examiner	1.	Decedent's Name (First, Middle,Last) Mehki Travis Doe		Date of Death Month Day October 15, 2009	Year 1546 hrs
N EXCENSION		Facility Name (if not institution, give street and number) 4b. Cit	y, Town, or Location of Death ver Spring		County of Death ontgomery
Funeral	5.	Holy Closs Hospital	nder 1 Year If Under 24Hrs.	8. Date of Birth (MM/D	D/YYYY) 9. Birthplace (State or Foreign
Director	1	20-83-4426 1X M 2 F Yrs. MQ	nths Days Hours Min.	3/06/200	
any		ual Residence of Decedent a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 X No
		Prince George's Beltsvi		10g Citiz	en of What Country?
2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shountie event, the Medit al Examiner must be notified at once. To Be Completed by Funeral Director	10	e. Street and Number 1376 Cherry Hill Road #201	Zip Code 20705	109. 0102	USA
ms 23a be noti		If Vac sr	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto l		 Race - American Indian, Black, White, etc.
or items 23	1	X Never Married 2 Married 1 Yes 2 X No	2 X No specify:		Specify: Black
atural" xamine	Դ⊢	5. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us during most of	ual Occupation (Give kind of w working life. DO NOT use retir		ind of Business/Industry
in 72 hours han "natur tical Exam pleted		Elementary/Secondary (0-12) College (1-4 or 5+) none		1	none
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Complet	3 1	. Father's Name (First, Middle, Last)		(First, Middle, Maiden	
d be fillental H arked event,	י ומ	Jonathan K. Doe Ja. Informant's Name/Relationship (Type, Print) 19b. Mailing Add		a Mulutu. Rural Route Number, Ci	tty or Town, State, Zip Code 20705
2 should and Mer 27 is maric ev	- 1	Cecilia Doe/Mother 11376	Cherry Hill	Road #2	01 Beltsville, Mc Location - City or Town, State
1 and 2 sho F Health and F item 27 is er traumati	2	Da. Method of Disposition X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other p	lace)		
Pages ment of tant: I		Donation 5 Other Specific			Silver Spring,Md
permit. Pages 1 a Department of He Important: If ite injury or other ti	1	NI. V. KI Week 19241	Columbia Bl	lvd Silve	SERVICE, P.A. r Spring, Md20910
hysician	1	Ba. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	ode of dying, such as cardiac o	or respiratory arrest, sho	ock, or heart Approximate Interval Between Onset and Death
'n dical aminer		mediate Cause (Final disease a Anoxic injury rondition resulting in death) Due to (or as a consequence of):			200
		equentially list conditions,	v support		
igi		anse. Enter Underlying Cause Due to (or as a consequence of):			
Sit Sit		Disease or injury that initiated vents resulting in death) Last Due to (or as a consequence of):			
m and	ᇹᅡ	X UNPENDED AMENDED PI line a-b, PII	27 28a-f.ne	rm.E 9900	2/18/10 TT
eath certificate be exe		FEMALE: 23c. If yes, outcome of pregnancy		20	Bd. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 60100, Ital or Attending Physician: The law requires that the death certificate be surs after death. Institute of After this certificate has been signed by the attending physicial lied in by the funeral director, page 2 should be detached for use as the bunal of the funeral director, page 2 should be detached for use as the bunal lied in by the funeral director.	cian	past 12 months?	(Specify)		
the attr	hysi	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the under	eriving cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ries that the de signed by the	اھ	Metabolic disorder, uncertain etiolog	у	1 Yes 2	✔ No 3 Probably 4 Unknown
ras, require been signould b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
ing Physician: The law requiring Physician: The law requiring After this certificate has been funeral director, page 2 should	d W			performed?	
ian: T	Bec	25. Was case referred to medical examiner? Hospital: 1 Input 2 FR/Outnation 3	26.Place of Death (Chec		dence 6 Other:
ing Physic After this	유	1 Ves 2 No Inpatient 2 Erroutpatient 2 7 Manner of Death 28a. Date of Injury 28b. Time of Injury		28d Describe how it	
on on on on on on on on on on on on on o	Ē	1 Natural 5 Pending 10/15/2009 unk	1 Yes 2 X No	matabalia	disorder dislodged
DIVISION Dispital or Attend hours after death meral Director; y filled in by the	Certification:	2 X Accident Investigation 3 Suicide 6 Could not be	factory, office building, etc.	28f. Location (Street or Town, State) Beltsvill	t and Number or Rural Route Number, City 11376 Cherryhill Ro e, MD
y fried by		4 Homicide determined (Specify) residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	d at the time, date and place, a	nd due to the cause(s)	and manner as stated.
To the I within 2. To the E complete	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurre	d at the time, date and t	d. Date signed (Month, Day, Year)
F 3 F 2	ž	29b. Arginature and title of certifier	O.C.M.E.		ctober 16, 2009
		30. Name and address of person who completed cause of death (Item 23a)			
		Victor Weedn MD JD Assistant Medical Examiner 111 Pe	nn Street, Baltimore, M	21201 	
Sta	ate rar	31. Date filed (Month, Day, Year) 2009 31. Registrar's Signary e			

	-	Please	-	aryland / De	Indelible Ink. epartment of H	lealth and l	Mental Hy	giene	e.
		Registrar 1. Decedent's Name (First, Middle, La			erillicate of t	Dealli	2. Date of De		3. Time of Death
Physicia /Medica	al -	John Thomas		ns 				1,2009	9:35p M
Examine	er	4a. Facility Name (If not institution, give				Location of Deat	h	4c. County of I	
Funeral		Arden Court P 5. Social Security Number 6. 5 537-10-1745	OCOMAC ex 7. Age M 2 F	e (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 1 2 / 0 5	Montgo th 19,74 (9.13)	Birthplace (State or Foreign Country) Colorado
Director	-	Usual Residence of Decedent		10c. City, Town o	ar Location				10d. Inside City Limits
e Maryla 8a-f shov	Director	WA. Whitma	.n	Pullm	an				1 ☑ Yes 2 ☐ No
th with th 23a or 21		10e. Street and Number 2501 Banner	Road		10f. Zip Code 991			10g. Citizen of Wha	A
Is a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 [XYes 2] If Yes, Give Year or Dates:	Ever in U.S. No 1941 – 1966	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖫 No	lispanic Origin? (S an, Mexican, Pueri Specify:	Specify Yes or No to Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc. White
21215-0036 d within 72 hours aft giene. ar than "natural", or the dien Exami	Completed	15. Decedent's E (Specify only highest gri	ducation ade completed) College (1-4or 5		ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	during most of wor d)	-	16b. Kind of Busin	v.of Texas
d 21;	Con	17. Father's Name (First, Middle, Last	5+	Di	rector o			, Maiden Surname)	
/lan(uld be t Mental mrked o atic eve	To Be	Thomas Bert E				Lizzi	e Aust:	i.n	
Mary and 2 sho alth and 27 is me		19a. Informant's Name/Relationship John T. Evans		19b. N	Mailing Address (Street	and Number or R	rive Po	otomac,M	d. 20854
Baltimore, Maryland sermit. Pages 1 and 2 should be file Department of Health and Mental Hymportant: If item 27 is marked othe any Injury or other traumatic event, page.		20a. Method of Disposition 1		20b. Place of Commetery, Ft. Bli	disposition (Name of crematory or other places Nat L	Cem10/	Date 19/200	20c. Location - Cit	ty or Town, State
Balti permit. Departr Importa any Inji		21. Signature of Funeral Service Lice	see Vialle						VICE,P.A. ring,Md2091(
		23a. Part 1. Ent the sease, or conshock, or heart failure. List only	iplications that caused one cause on each li	the death. Do no					Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pneun Due to (or as	nonia a consequence of);				
Examiner	-	Sequentially list conditions,	b	a consequence of					
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o, injury that initiated events	с						
	_	resulting in death) Last	Due to (or as	a consequence of					
/ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date Monti	
S, P. es that I igned by	by Ph	Part II. Other significant conditions		out not resulting in t	he underlying cause gi	ven in Part I.			ute to the cause of death? Probably 4 X Unknown
COrd w requir s been s should	leted	advanced_dem	entla				24a, Was	s an 24b. We	ere autopsy findings available
rai Ke in: The la ificate ha or, page 2	Comp	25. Was case referred to medical	T.			26 Place of De	perf	ormed? de 2½ No 1	or to completion of cause of ath? □Yes 2 □ No
† VIII	ro Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outp	patient 3 DOA Ot		Home 5 ☐ Res	sidence 6 🗷 Other	(Specify)assisted
Division of Vital Records, or Attending Physician: The law requires that deter death. Director: After this certificate has been signe tin by the funeral director, page 2 should be or	ation:	27. Manner of Death 1 → Natural 2 → Accident 5 → Pending investigation	28a. Date of Inju (Month, Da	ury 28b. Ti ay, Year) Inj	ury Wo	ıry at rk?]Yes 2 □ No	28d. Describe	how injury occurred	living
DIVISION Of VITAI REC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	3 Suicide 6 Could not 4 Homicide determine	Zee. Place of in	jury - At home, farr tc. <i>(Specify)</i>	n, street, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
Hospita 24 hours Funeral etely filler	Medical C	29a. Certifier 1 🙀 Certifying F (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner si	of examination and	death occurred at the look or investigation, in my	time, date and plac opinion, death occ	ce, and due to th	e cause(s) and man e, date and place, ar	ner as stated. nd due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier		2.0		se number			(Month, Day, Year) 2 , 2009
25.41		30. Name and address of person who	completed cause of	death (Item 23a) (1					

Registrar DHMH 17 Rev 1/2001

State

Roy Fried M.D.

31. Date filed (Month, Day, Year)

OCT 15 2009

6430 Rockledge Dr. #470 Bethesda, Md. 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	Department of Health and W Certificate of Death		giene 2009	34603
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea	r 18, 2009	3. Time of Death 6:10 A M
	/Medic Examin	al	MaryLouise Easterday 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Octobe	4c. County of Deat	h
,,,	Funeral		Ravenwood Lutheran Village 5. Social Security Number 6. Sex 7. Age (In yrs. last by	Months Davs Hours Min.	8. Date of Birt (Month, Day Jan • 2!		hplace (State or Foreign untry)
	Director		220-16-0822 1□ M 2X F 97 Usual Residence of Decedent	Yrs.	Jan. 25	5,1912 Mar	yland 10d. Inside City Limits
	Marylar a-f show	tor	10a. State 10b. County 10c. City, Tow Maryland Washington County Hager				1 □Yes 2 No
	or 28)ire	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?
	23a c	ral	18630 Carolyn St.	21742		U.S.A.	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Evant at must be indifficult at once.	by Funeral Director	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 □Yes 2▼No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
2-003p	houn tural	pa p	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a	a. Decedent's Usual Occupation	-	16b. Kind of Business/	Industry
0171	within 72 ene. than "na	Completed	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of worki life. DO NOT use retired) egistered Nurse	ng	Nursing Ho	ome
ט ס	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)		(First, Middle,	Maiden Surname)	
/iand	Ald be fental riked tic ev	To B	Tryon Bragunier	Annie R	ice Bra	gunier	
Mary	shou and N		19a. Informant's Name/Relationship (Type. Print) 19	b. Mailing Address (Street and Number or Run	al Route Numbe	er, City or Town, State, .	Zip Code)
	and 2 ealth n 27 i			06 East Hillcrest Rd.			
saitimore,	Pages 1 nent of H ant: If iter ary or oth		1 M Burial 2 I Cremation 3 I Hemoval from State	ery, crematory or other place)	9-2009	20c. Location - City or Hagerstown	
סמונ	permit. Departi Imports any inj	j	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Dou 1331 Eastern Blvd.	0	,	
		1	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	Melanama			Onset and Death 5 4-Covs
	Examiner	ner	Sequentially list conditions, if any, leading to huma dieto cause. Enter Underlying Cause (Disease or injury that initiated events cause.	:3f)·			
	executed n and al-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c	e of):			
08/00,	cate be physicia the buri	ical	d				
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
ras, r	quires that n signed b uld be deta	ğ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		obacco use contribute t Yes 2 ☐ No 3 ☐ F	
Records,	The law rec te has bee age 2 shou	Completed			24a. Was autor perfo	an 24b. Were a prior to death?	utopsy findings available completion of cause of
VItal	an: '	BeC	25. Was case referred to medical	26. Place of Deat			
>	nysici nis ce direc	으 문	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 ☐ Resi	dence 6 ☐ Other (Spe	ecify)
0	ng Ph fter th neral	L:uc	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b	Time of 28c. Injury at Injury Work?		how injury occurred	
IVISION	or Attending I fter death. Nirector; Atter n by the funer.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	M 1 □ Yes 2 □ No farm, street, factory, office	28f. Location (City or To	Street and Number or F wn, State)	lural Route Number,
2	te Hospital of 24 hours a le Funeral Diletely filled is	Medical Cel	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
—	To the within To the comp	Me	29b. Signature and title of certifier While the control of the certifier and the ce	29c. License number D26365		29d. Date signed (Mon	
		1	· · · · · · · · · · · · · · · · · · ·				

State Registrar

OCT 19 2009

Rigistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Ctober Day Wilfred C. Edwards 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital P.G. Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours Min. TXXM 2 ☐ F Guyana, 212-45-9073 84 1-22-25 Usual Residence of Decedent 10a. State 10h County 10c City Town or Location 10d. Inside City Limits MD. P.G. Suitland ty Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Silver Park Terrace 4078-20746 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 3 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Painter Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Beaton Esther Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Edwards/Son 4703 Cooper Lane, Landover, Md. 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glenwood Cemetery 10/17/09 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Hackett's Funeral Chapel, W. cla Nachut 814- Upshur Street, N.W. DC 23a. Part 1. Arter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MAUGNANT CARDIAC disease or condition resulting in death) Due to (or as a consequence of): PERTEN SION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): DNE Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 | Pending 2 Accident Investigation 1 Tes 2 🗆 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner executed and Box 68760, physician certificate be the attending p P.O. ed by the a Division of Vital Records, pg a page 2 Physician: The certificate director

After or Attending 24 hours after death. Funeral Director: A filled in by the Hospital

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

ed other than "natural", or items 23a or 28a-f show event, the Medical Examples an inust be notified at

Baltimore, Maryland 21215-0036

permit. Fages 1 and 2 should be filed wir Departm..nt of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event

Physician

State Registrar

completely

To the within 2

3

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MDD 58/82

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

PAKKWAY SOITS # 1014 GREENBUT, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7500 HANDUELL 32. Registrar's Signature

		•	/pe or Print in B					_	
		For State Registrar	State of Maryland		eate of Death			No. 2009	34605
hysicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 300 4a. Facility Name (If not institution, give st	reet and number)	Fore	Sity, Town, or Location		Date of Death Month	Day Year 7 00 6	
uneral		5. Social Security Number 6. Sex	n Rd 7. Age (In yrs. le	Mont		Ar la er 24 Hrs. 8 Min.	Date of Birth	Prince (9. Bir	thplace (State or Foreign ountry)
rector		577 - 22 - 2692 Usual Residence of Decedent 10a. State 10b. County		Yrs.		<u> </u>	May 11, 1		10d. Inside City Limits
or 28a-f s	Director	Maryland Prince Ge 10e. Street and Number	uze Up	per 10f.	Marlboro Zip Code		10g.	Citizen of What Co	1 ☐ Yes 2 ☐ No ountry?
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Extrainter must be notified at once.	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates:	If Yes,	CO772—ecedent of Hispanic Ospecify Cuban, Mexica	an, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Whit	
er than "natura , it e Modicel E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	`life. DO NO	Usual Occupation f work done during mo T use retired)	ost of working		Federal Guvern	1
narked oth	To Be (17. Father's Name (First, Middle, Last)		Ford	E	Tigabe	First, Middle, Mai	For	(
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Important any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	3 19	22. Nam Ada	e and Address of Faci	ility 1 Hun	u PA,	Aguazes	MD 20608
sician edical miner		23a. Part 1. Enter the discusse, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		BTIVE			LURE	. 0	Approximate Interval Between Onset and Death 2 WESS
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icate has bee , page 2 sho	Completed	CORONARY A	RTORY DIS	EASE			24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of s 2 No
To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 Alatural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At ho building, etc. (Specification)	28b. Time of Injury M me, farm, street, fac	DOA Other: 4 1 1 28c. Injury at Work? 1 Yes 2	Nursing Home 28	d. Describe how	et and Number or F	ecify) Rural Route Number,
Funeral Di		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examina	wiedge, death occu			nd due to the cau	se(s) and manner	
To the complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number		29d	Date signed (Mor	nth, Day, Year)
7		30. Name and address of person who con NELSON BEN	npleted cause of death (Item DERS, 9131	23a) (Type, Print) PISCAT	miny,	ROAD	CLIN	NOW, I	no 20731
Sta Registr		31. Date filed (Month, Day, Year) OCT 13200	32. Fegistrar's Signal	B. park	led				

State of Maryland / Department of Health and Mental Hygiene 2009 34606 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** FRAZIER EDWARD 4:00AM 09 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MOTCOMERY SILVERSPRING LAYHILL GENESIS CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F MD Director 1/31/39 220-34-7822 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or hitem hist be nothing any or other traumatic event, Ite Medical Experiment must be nothing at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA 13411 Fairland Park Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Backhoe Operator Contruction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Frazier John Williams ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tratence. 15015 Seneca Rd, Rt 2, Germantown, MD 20874 Roger Genies - son 20a. Method of Disposition 20b. Place of Disposition (Name of competery) crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 🖊 🖾 Cremation 3 🗆 Removal from St 4 □ Donaglop 5 □ Other (Specify) 10/19/09 Dickerson, MD Cemetery Warren 21. Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Described the shock, or heart failure List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CANCER. **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner's 1 Yes 2 No Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours aner coc....

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 12 Cextifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifier th (Item 23a) (Type, Print)
3227 Bel Pie Road Selversprig M020906
s Signature 30. Name and address erson who completed cause of death (Item 23a) (Type, Print) Husoun 2. Registrar's Signature 31. Date filed-(Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct. 11, 2009 **Physician** Joseph Vincent Fitzgerald 6:00a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lorien Mt.Airy Mt.Airy Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9 17 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours **1** M 2 □ F 90 220-01-5830 Maryland Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show Item 27 is marked other than "natural", or Items 23a or 28a-f shot other traumatic event, the Wedical Exercities into the control of the cont MD Montgomery 1 ☐ Yes 2 X No Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 415 Silver Spring Ave.#611 20910 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?
1 XYes 2 □ No 1941.
If Yes, Give Year or Dates: 1945 within 72 hours after 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) filed withir Hygiene. Elementary/Secondary (0-12) Federal Gov't Postal Clerk 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Garrett A.Fitzgerald Mary Nolte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. PrinGuardian 2407 Flag Marsh Road Mt.Airy, Maryland 21171 Linda Bonifant-Travers/ 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Cemetery10/16/2009 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Glen, Md. 4 □ Donation _5 □ Other (Specify) 21. Signature U uneral Service PHITIPADES TINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Box 68760. physician Physician/Medical the attending p IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 0 ☐Yes 2☐No detached 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 PNo Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 ☑ Other (Specify) Hospital: Other: 4 Nursing Home 5 Residence 2 No. 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 P Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier License number

State Registrar Name and address of person who completed cause of

Year)

32 Registrar's

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the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifi mpletely filled in by the funeral director, To the 1 3PE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201 . Registrar s Sigi

29c. License number

O.C.M.E.

Medical

State Registra

October 22, 2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Of IVI	arylano	Depa ו <i>Cer</i>	tificate of L	eaith and r Death	vieritai myg F	leg. No. 20	109	34609
ш			Decedent's Name (First, Middle, Last)					2. Date of Dea Month / A			3. Time of Death
	Physicia /Medic	al .	Keith Theron Fisher					10	4c. County	2009	6:46 PM
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and be file	ntal H	Be	17. Father's Name (First, Middle, Last) Jacob Peeden				18. Mother's Nan Ada Spa		Maiden Surnai	me)	
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ore	t of Healt If item 2 or other		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State	20b. Pl	ace of Dispo metery, cren	sition (Name of natory or other place	ce)	Date	20c. Location	1	
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Baltimore,	permit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "any fijury or other traumatic event, it a histogre.		21. Signature of Funeral Service Lice	41	22	2, Name and Addres	s of Facility Uneral Ho	ome, P.A.		
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5	Physi this c	10	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie		4-4-Nursing no	me 5 Resider	nce 6 Other (Spe	icify)
0	ding th. : After s funer	tlon	1 ■ Natural 5 Pending 2 Accident investigatio	(Month, Day Yea	r) Injury	Worl	k? Yes 2 □ No	20d. Describe not	williary occurred	
UNISION	or Atter after dea Director in by the	ertification;	3 Suicide 6 Could not be determined		At home, farm, st ecify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Fureral Director: After this certifical completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exer	nysicien: To the best of my miner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	th occurred at the time	ne, date and place, pinion, death occurr	and due to the car red at the time, da	use(s) and manner at te and place, and du	s stated. e to the cause(s)
	ro the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	29	d. Date signed (Mon	th, Day, Year)
)	. > - 0		•	m_		104	3725		10/9/0	9
	DB 3		30. Name and address of person who	completed cause of death (1tem 23a) (Type,	Print) 19 Re	idge 1	Road	Westm	Inster d 21157
	Sta Registr		31. Date filed (Month) Day, Year) OCT 14	32. Registrar's S	gnature B. A	barker			M	d 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34611 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 7 Day 2009 Year Virginia Louise Greenfield 4:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Annapolitan Care Center Annapolis Social Security Number 9. Birthplace (State or Foreign Country) Arizona If Under 1 Year | If Under 24 Hrs. 6. Sex . Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days 1 □ M 2 👿 F Hours 4723/1918 491-18-0178 91 Director Usual Residence of Decedent show 10b. County 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 💢 No Annapolis Maryland Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 River Drive 21403 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary U.S. Congress years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irma Smith Norman McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 River Dr., Annapolis. MD 21403 Robert M. Greenfield/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or Kalas Cremation 4 Donation 5 Other (Specify) 10/8/09 Edgewater, MD 21. Signature of Juneral Service 1 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line 30 days Immediate Cause (Final Physician. Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hyponatremia, normal pressure hydrocephalus 2 No 3 Probably 4 Unknown Completed 1 Yes HTN, Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury accurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 0060863 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Erika M. Benns, 139 Old Solomons Island Road, Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 10, 2009 Physician 8:15 PM CLARENCE J. GREENLEE, JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital FREDERICK Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Wash. **Ж**ДМ 2□ F 1941 67 **Director** 213-40-6211 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dipartment of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be muffled at outs. 1 Yes 2 No Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 24324 Log House Road 20882 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Read Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Greenlee, Sr Louise Carter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24324 Log House Road, Gaithersburg, MD 20882 Delores E. Greenlee (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/17/09 Gate of Heaven Cem Silver Spring, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Signature of Funeral Service 246 N. Washington St, Rockville, MD 20850 art 1. Enter the dise, se, or complications that caused the death shock, or heart failure. List of young cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur. List Immediate Cause (Final disease or condition resulting in death) Physician 60 Minutes Cardiogenic Shock /Medical Due to (or as a consequence of): **Examiner** Myocardial Infarction 10 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an End stage Renal Disease on hemodialysis autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/10/09 D66599 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 180 Thomas Jefferson Dr., Frederick, MD 21072 Stephen B. Williams, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

OCT 15 2009 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 13, 2009 ar **Physician** 2:10 PM M Martha **GOREN** Charlotte /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery 7420 Westlake Terrace #811 Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth May 5, 1926 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months 577-26-2673 83 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Montgomery Bethesda Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 20817 United States 7420 Westlake Terrace #811 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any injury or other traumatic event, If a Me any injury or other traumatic event, If a Me any injury or other traumatic event, If a Me any injury or other traumatic event, If a Me any injury or other traumatic event, If a Me and a donce. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Platt Rose Caplan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7420 Westlake Terrace #811, Bethesda, MD David Goren, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden 10/15/09 Falls Church, VA 21. Signature of Faceral Service Licensee TOPENTHISKYSSHEDWew Funeral Home #MOI 008 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 2 Months **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed I physician and s the burial-trans Due to (or as a consequence of): P.O. Box 687604 Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Emphysema 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performet? 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 🛣 No Hospital: 5 A Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Manner of Death 1∕Ω Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 □ Yes 2 □ No n 24 hours after death.

le Funeral Director: A pletely filled in by the fu death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier C October 14, 2009 D 43083 30. Name and address of person who completed on se of death (Item 23a) (Type, Print) 5707 Medical Center Dr., #300, Rockville, MD George D. Sotos, M.D 31. Date filed (Month, Day, State Registrar 5

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Jerwin Eugene Hines /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cumberland

1 Year | If Under 24 Hrs. 8. Date
(Mo Allegany 9 Birthplace Country) Braddock Campus- WMHS If Under 1 Year 8. Date of Birth (Month, Day, Year) May 31, 19 (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1 M 2 □ F 65 232-72-9884 1944 Keyser, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Maryland Examination at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director WV Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Rt. 1, Box 143 Funeral 26726 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) WV Department of Elementary/Secondary (0-12) College (1-4or 5+) Store Room Clerk Highways 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ William T. Hines ပ္ Anna Frances Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda S. Hines/Wife Rt. 1, Box 143 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 2009 4 □ Donation 5 □ Other (Specify) Cumberland, MD 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Education Programment of the Control of Secured Programment of the Control of Secured Programment of the Control of Secured Programment of Secu CEREBROVASCULAR
Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 00 25 406 ann M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Cumberland, Maryland Seton 900 GM. Urive ann 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

			1 - State of Maryla Registrar	and / Depa <i>Ce</i>	artment of I rtificate of	Health and Death	Mental Hyg	ilene 200	9 3461
	Physic /Medi		Decedent's Name (First, Middle, Last) FRANCES MARY HECK				2. Date of Deat Month OCTOBER	Day Yea 21 2009	3. Time of Death
4	Exami		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPIT		FREDERI			4c. County of De	
	Funeral Director		5. Social Security Number $120-16-1055$ $1 \square \text{ M} \ 2 \square \text{X} \text{ F}$ $1 \square \text{ M} \ 2 \square \text{X} \text{ F}$ $1 \square \text{ M} \ 2 \square \text{M} \text{ F}$ $1 \square \text{ M} \ 2 \square \text{M} \text{ F}$	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. E 924	Birthplace (State or Foreign Country) NY
	ne Marylanc 8a-f show	Director	10a. State 10b. County 10c. MD Frederick	City, Town or Lo Frederi					10d. Inside City Limits 1 X Yes 2 □ No
	with the	II Dir	10e. Street and Number 406 Center Street		10f. Zip Code 21701		11	0g. Citizen of What (Country?
920	filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23a or 28a-f show ont, the Medical Examinar must be molified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates;		Was Decedent of H fYes, specity Cuba	tispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, Wh	merican Indian, nite, etc. Vhite
215-0	ithin 72 hours ne. nan "natural", nedical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done OO NOT use retired	eation during most of world)	rking	16b. Kind of Busines	
Maryland 21215-0036	d d d	Be	12 17. Father's Name (First, Middle, Last)	Ho	omemaker		ne (First, Middle, N	Own Home	
Ž	d 2 should then and Men Ith and Men Ith and Ith and Ith Ith Ith Ith Ith Ith Ith Ith Ith Ith	၉	Guiseppe Rizzi 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street	Grace D		City or Town, State	Zin Cada)
	1 an Hea em 2		Kathleen Tokar Daughter	1323		il Lane	Frederick	MD 2170)3
Baltimore,	9 - 5		4 Donation 5 Other (Specify)	es thaver	n Mem Grd	n 10-2	4-2009 F	rederick,	Maryland
Bal	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Lice Lea	$\begin{vmatrix} 22 \\ 1176 & 10 \end{vmatrix}$. Name and Addres)6 East C	^{ss of Facility} Ke hurch St	eney & Ba reet Fred	sford P.A lerick, MI	. F.H. 21701
	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if my, leading the minute of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consider that the conditions of the condit	quence of: Te Rei	ncl fail		c or respiratory arre	ist,	Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	ledical E	d.	aquence ory:					
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	lelivery Day Year
Records, F	w requires that the de been signed by the a should be detached f	۾	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause give	en in Part I.			to the cause of death? Probably 4 - Unknown
tal Reco	hysician: The law ru his certificate has be i director, page 2 sho	Completed	25. Was case referred to medical				24a. Was an autopsy perform	ed? prior to	autopsy findings available completion of cause of s 2 \square No
of Vital	Physician: r this certific ral director, p	Ω	examiner? 1 Yes 2 No Hospital: 1 Impatient 2	TER/Outpatient	3 □ DOA Othe		th (Check only one) nce 6 □Other <i>(Sp</i>	
Division o	ding P	Certification: To	27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be	28b. Time of Injury	28c. Injury Work M 1 🗆		28d. Describe how	v injury occurred	
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	cify)			City or Town,	State)	Rural Route Number,
	To the Hospital within 24 hours and the Funeral I completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my king the past of examinents on the basis of examinents and manner stated.	nowledge, death nation and/or inv	estigation, in my of	oinion, death occu	, and due to the ca rred at the time, da	use(s) and manner attention and place, and du	as stated. le to the cause(s)
	S or Witi	2	29b. Signature and title of certifier		29c. License			d. Date signed (Mono) $0/22/09$	th, Day, Year)
_	V	;	30. Name and address of person who completed cause of death (lite	em 23a) (Type, P	rint) M, Fred	lerick, M	D 21	701	
	Stat	-	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	, -, -				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No.

			For State Registrar	State of Ma	ryiand /	Ceri	rtment of F tificate of	neaith and i Death		eg. No.	34616
Н	Physicia		1. Decedent's Name (First, Middle,	Last)	14	EIBI	ก		2. Date of Deat Month	Day Year	3. Time of Death
-	/Medic Examin		4a. Facility Name (If not institution, Anne Arundel				4b. City, Town, o	r Location of Death	(4c. County of De	
-/	Funeral				(In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 28	(year) 9. Bi	rthplace (State or Foreign Country) nnsylvania
	Director		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation		DCC . 201	, 1937 10	10d. Inside City Limits
e Marvis	8a-f sho	ector	Maryland Anne	Arundel			A	nnapolis			1 □Yes 2 🗷 No
th with th	23a or 2 ant be n	Funeral Director	10e. Street and Number 1009 Old Bay Ri	.dge Road			10f. Zip Code	21403]	0g. Citizen of What C	
Ind 21215-0036 he filed within 72 hours after death with the Maryland	Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Even than in ust be mutilied at		11. Marital Status 1 ☐ Never Married ※XX Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba □Yes 2 【本No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	n "natur Akdigal	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	t grade completed)		6a. Decede (Give k life. D	ent's Usual Occup ind of work done O NOT use retire	oation during most of work d)	king	16b. Kind of Busines	
212 ed with	lygiene ner tha rt, the			College (1-4or 5+	Pe	erson	al Prope	erty Appra		Apprais Maiden Surname)	als
/land	is marked other than aumatic event, Inc.	To Be	17. Father's Name (First, Middle, L Vedder White	ast)					Shaughne		
	サマサ		19a. Informant's Name/Relationsh John L. Heibel		1	9b. Mailing 1009	Address (Street Old Bay	and Number or Ru Ridge Roa	ral Route Numbel ad Anna	r, City or Town, State polis, Mar	zip Code) Yland 21403
Baltimore,	nent o		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			Mary'		ery 10/1	4/2009	20c. Location - City of Annapolis,	Maryland
Balt	Depart Import any inj once.	, (21. Signature of Funeral Service L	icensee	Mu					ylor Funer , Annapoli	al Home s, MD 21401
	hysicían	5 5	23a. Part 1. Enter the disease, or one shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused only one cau e on each line	the death. De.	o not ente	r the mode of dyi	ng, such as cardiac	or respiratory arr		Approximate Interval Between Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	consequence	ce of);	menn	in			10-140
petr	J insit	Examiner	Seque delty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	ce of): (
68760, tificate be executed	physician and the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	consequen	ce of):					
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal de	ath 3 🗌	Ectopic pregnance	су		23d. Date of o	lelivery Day Year
P.O. Lat the de	by the a	Physician/M	1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of deati	n 5⊔	Other (specify) _				
rds, I	been signed by the should be detached		Part II. Other significant conditio	ns contributing to death bu	t not resulting	g in the un			23e. Did to		to the cause of death? Probably 4 Unknown
I Records, P.O. Box The law requires that the death cer	ite has bee	Completed by	6 p post B	c Ca Ez op	HAG	as,	metar	titic	24a. Was a autop perfor 1 □Yes	sy prior t med? death	autopsy findings available occumpletion of cause of ?
Vital sician: ⊺	this certificate has al director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Ott	OF:	th (Check only or	ne)	
n of	Affer	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Injur (Month, Day	nt 2 🗆 ER/ y (Year) 28		28c. Inju	ry at		ence 6 Other (S) ow injury occurred	pecify)
Divis	within 24 hours after death. To the Funeral Director: A completely filled in by the form	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ry - At home . (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
Div To the Kospital or	e Funera letely fille	edical (g Physician: To the best of Examiner: On the basis of and manner star	examination						
To th	withir To th comp	Me	29b. Signature and title of certifies	20	A		29c. Licens	se number	> 2	29d. Date signed (Mo	nth, Day, Year)
			30. Name and address of person	tho complete cause of de	eath (Item 23	la) (Type, F	Print)	11		1 and	M D 2140)
CH	5	ta	MICITAEL - 31. Date filed (Month, Day, Year)	J. La ENTY 32. Registra	A iun	4 4	IT VEF	ENSE 17	19 HWA	MANTPOLI	W 172140)
	Sta Registr		nct 1	3 2009		1 1	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DEI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10907 Tyrone Drive Prince George's Upper Marlboro 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Yea Sept 14, 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 M 2 D F Months Days Hours Min. **Director** 499 38 3621 74 Missour Usual Residence of Decedent fshow filed within 72 hours after death with the Maryland al Hygiene. 3 other than "natural", or items 23a or 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. 1 ☐ Yes 2 🏋 No <u>Upper Marlboro</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10907 Tyrone Drive 20774 United States or than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Ş 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Air Force Retired permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubert Hoelscher Helen Gerhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hoelscher (Wife) 10907 Tyrone Drive, Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Lee Crematory 4 Donation 5 Other (Specify) October 10, 2009 Clinton, MD 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Signature of Funeral S Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Insertand Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year ☐ Pregnam. ☐ Unknown Pregnant at time of death 1 ☐ Yes ∠ ☐ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No 2 \square No 1 🗌 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗍 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature•and **t/tl**e of

State Registrar EYENSE

776/W/1

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 0050 A M Elizabeth Howard /Medical Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Eninsula Kecional Medical Center Calisbury WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕇 F Days Hours 218-20-9532 82 Director 03/05/1927 Virginia Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hadical Examinating ust by rectined at Director Maryland Somerset Westover 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 31436 Rehobeth Road 21871 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify þ white Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) inspector food processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Williams Sr. Josephine Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important; If item 27 is
any Injury or other trau Donald Howard/son 12 Wharf Court, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/14/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Fungral Service Licensee Holloway Funeral Home, professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of Exami burial-trans and Due to (or as a consequence of): Box 68760. physician Physician: The law requires that the death certificate be Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 2 X No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D68552 30. Name and/address of person who completed cause of death (Item 23a) (Type, Print) DA 5 AD1Q. SAlisbury 100 E. arroll St. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1 4 2009

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Charlotte Falconer 10, 7:45 P M October | 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens at Charlestown Catonsville Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F 102 Director Nov. 1906 215-44-5221 6, Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Its McJical Evand and in the matter of the most be morthed at Director 1 ☐Yes 2√ No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 709 Maiden Choice Lane 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent 11 U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Eldred ၉ Falconer Annie Elizabeth Koogle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Falconer - Nephew 7 Lamar Lane, Middletown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 10/12/09 Alexandria, Virginia 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Kovert 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of): burial-P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) the detached 9 ☐ Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 st 24a. Was an autopsy performed? 2 🗆 No 1 □Yes 201No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1∐ Yes 2 DNO Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural death. n 24 hours after death.

e Funeral Director: A letely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ander 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death **Physician** October ^{Day} 11 200ອື JUNE WANETTA HATIT 04:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🗷 F 214-32-2566 75 Maryland **Director** 25 1934 June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "Medical Experience and by natified at Director Md. 1 ☐Yes 2 No Gaithersburg Mantgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9305 Emory Grove Road 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No <u>۾</u> If Yes, Give Specify Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H Be William Frank Fann ie E. Monroe ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 Jack Walker Hall / Husband 9305 Emory Grove Road, Gaithersburg, Md. permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metropolitan Crem. 10/12/09 Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 20882 P. O. Box 5038, Laytonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ULTRA CEREBRAL HEMORRHAGE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 □ Yes 1 ☐Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

ne Funeral Director: Affinetely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) To the I within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D68178 (ane; MT) 10-11-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 9901 Medical Center Drive, Rockville, Md. Santosh Rane, 31. Date filed (Month, Day, Year) 32. Regis rar's Signature State Registrar

To the Hospital or Attending Physician: within 24 hours after death. within 24 hours aft To the Funeral Di completely filled in

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD.

32 Registrar's Signatu 31. Date filed (Month, Day, Year) OCT 07 2009

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O.C.M.E.

October 6, 2009

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Registra

State of Maryland / Department of Health and Mental Hygiene 2009 34622 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Year Helen Louise Kling October 2, A M 1:13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 11026 Simmons Road Taneytown Frederick 8. Date of Birth (Month, Day, Ye June 21, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1934 Days Months Hours Min Maryland 218-32-7859 75 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show the Medical Examiner mass be notified at 10d, Inside City Limits Director 1 ☐ Yes 2XXNo Maryland Frederick Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11026 Simmons Road 21787 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Inc. M. Elementary/Secondary (0-12) College (1-4or 5+) 12 Pharmacy Technician Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. Carr Ada Bull ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Gillespie / Daughter 1245 Bigler Rd., Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 2, 1 ☐ Burial 2 X Cremation Resthaven Crematory 4 ☐ Donation ☐ Tother (Specify) 2009 Frederick, Maryland of Funeral S rvicelicensee 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease condition Physician disease condition resulting in death) /Medical Due to (or as consequence): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? Yes 22No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and the 29d. Date signed (Month, Day, Year) D0067468 10/2/09 on who completed cause of death (Item 23a) (Type, Print) 555 South Catac Street GEZHINZER. bhitkiarang 32. Registrar's Signature State OCT 0 6 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar 34623 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death oc¶öber 2ďď9 ROLAND EUGENE KINGSBURY 3:15P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WALKERSVILLE FREDERICK GLADE VALLEY NURSING HOME If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Y JULY 22 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 2^{Year}1929 1**X** M 2□ F Days Months Hours 220-28-5465 80 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MONTGOMERY DICKERSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20842 USA 19211 PEACH TREE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE FARMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AMBROSE C. KINGSBURY MYRTLE WALTERS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY KINGSBURY / SPOUSE 19211 PEACH TREE RD., DICKERSON, MD 20842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MONOCACY CEMETERY 10/8/09 BEALLSVILLE, MD 22. Name and Address of Facility HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20838 BARNESVILLE, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day rt I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Certification: To

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29a. Certifier

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygiene. Important: If time 72 Is marked ofher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, it is Mocited Examinating the northrol at

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

Division of Vital

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the I

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attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed the signed I has e 2 s After this certificate he funeral director, page

1 □Yes 2 □No 9 □ Unknown	9 Unknown	5 Li Other (specify)
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Par

كالملاصد 25. Was case referred to medical 26. Place of Death (Check only one)

24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No
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(Specify)

6-2009

examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1
27. Manner of Death	28a. D
1 Natural 5 ☐ Pending	(A
2 Accident investigation	1
a T O C T Could and be	. –

	1 Inpatient	2 🗆	ER/Outpatient	3 🔲 [DOA	4	🗷 Nursing H	lome	5 Residence	6 ☐ Other
28a.	Date of Injury (Month, Day, Ye	ar)	28b. Time of Injury	М	28c.	Injury at Work? 1 ∐Yes	2 □No	28d.	Describe how inju	ury occurred

ice

4 ☐ Homicide	determined	28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)
a. Certifier	1 Certifying Physi	clan: To the best of my knowledge, death occurred at t

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)	2 ☐ Medical Exami	ner: On the basis of and manner sta	examination and/or in ted.	٧
29b. Signature and	title of certifier		0	

occurred at the time, date and place, and due to t estigation, in my opinion, death occurred at the tim	
29c. License number	29d. Date signed (Month, Day, Year)

10. SI	ature and tipe of certifier
	NV 111 1 and Court
	- Committee of the comm
. Naı	and address of person who completed cause of death (Item 23a) (Type, Print

200, License number	23u. Da
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1 rouge CRNA 1475 Lavey 32. Registrar's Signature 1. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dorothy Mae Littleford 4:51 PM itone i /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Plata Merlical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3, 1924 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Days 577-80-0321 1 ☐ M 2 🖾 F Washington DC 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, It a Madical Evantine must be notified at 1 ☐ Yes 2 ☑ No Director Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2109 Country Pines Court 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □vNo Specify. δ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f. Department of Health and Mental Important: If item 27 is marked of any injury or other tramment. William Jennings Baxter ဂ Mary Kindness Satterfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Valentine/Daughter 2109 Country Pines Court, Waldorf,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/15/09 Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00945 avil AREHART-ECHOLS FUNERAL HOME, P.A. 0 でかい 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Mary's Ave. La Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner ona Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 TYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

Physician: The law requires that the death certificate be executed burial-tran and Division of Vital Records, P.O. Box 68760, attending physician for use as the burial peen (has certificate director this funeral After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the filled in by

72 hours after

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al Hygiene.

10-12-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fort Washington, MD 2074 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Carole Jean Lorenzen 9 2009 11:25 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Crownsville Fairfield Nursing Home Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) May 3, 1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 XX 217-38-4081 68 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, It e Madical Examiner must be notified at Maryland Anne Arundel Crownsville 1 ☐ Yes 2000No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò U.S.A. 1454 Fairfield Loop Road 21032 Funeral items. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes XXNo Specify. Specify: White ş 3XXWidowed 4 ☐ Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health, and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Mones. Bookkeeper State of Maryland 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alden F. Simmons Lois Miller ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 143 Worcester Road Stevensville, Maryland Katherine Barron/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 10/12/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 00 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ue to (or as a consequence of): lamme disease or condition resulting in death) /Medical Examiner Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ■ No Pregnant at time of death 5 ☐ Other (specify) ed by the 9 I Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate | 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ANO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Aftert 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

22 31. Date fled (Month, Day, Sw Glen Burne

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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09-07918
Judy Long

dy Long	1- For State	State of Maryl	land / Depar <i>Certi</i>	tment of ificate of	Health and <i>Death</i>	Mental		eg. No.	200	9	3462
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ledical Examiner	Judy Lor			T 41	o. City, Town, or L	ocation of De	October 1		ty of Death		
		t institution, give street and r			Conowingo			Cecil			
Funeral	5. Social Security Num		7. Age (In yrs. las	st birthday)	If Under 1 Year		Hrs. 8. Date of Bir	th(MM/DD/Y)	Foreig	an No	rth
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th the Maryland 23a or 28a-f sho notified at once	10 Crabbe				2	1918	l.	Ţ	JSA		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status	12. Was D	Decedent Ever in U.S	6. 13. Was	s Decedent of Hisp es, specify Cuban,	oanic Origin? Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)		ace - Ame hite, etc.	rican India	n, Black,
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21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natural cevers, the Medical Examin To Be Completed by	17. Patrier 3 Name (Fin						Name (First, Middle,	Maiden Surn	ame)		
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Baltimore, permit Pages I as Department of He Important: If ite	21. Si of Fune	ral Service Licensee		l D	ame and Address	d Fund	eral Home	, P.A.			
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ted Insit	events resulting in de		as a consequence o	of):							
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). Box 68760, the death certificate by the attending physic ched for use as the burner in an imperior and many many many many many many many many	1 Yes 2 No	0 - d 11-1-1	nknown	eath 5 C	other (Specify)						
ires that the de signed by the dedetached for the detached	cant conditions contributi	ng to death but not r	resulting in the	underlying cause	given in Part		tobacco use			-	
P.C.	<u> </u>										Unknowr
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eco he law ate has	——————————————————————————————————————							s 2 V No	1	Yes	2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safe from the rank from the rank from the from the funeral director, page 2 should be detach	25. Was case referre					Louis	Check only one)	Davidana		ther: Scene	
Whysic rithis call direction	1 Yes 2 27. Manner of Death		Inpatient 2 Date of Injury	ER/Outpatier		ury at Work?	Nursing Home 5	be how injury			
n of iding 1 h. Afte		5 Pending	Month, Day,Year)			Yes 2	1				
Sio	2 Accident	Investigation 28e	Place of Injury - At h	home, farm, str	eet, factory, office	building, etc		n (Street and	Number o	r Rural Rou	ute Number, C
Div	1X Natural 2 Accident 3 Suicide 4 Homicide		ecify)								
		Certifying Physician: To the Medical Examiner: On the b	e best of my knowler	dge, death occ	urred at the time,	date and plac	ce, and due to the c curred at the time, d	ause(s) and rate and place	nanner as , and due t	stated. to the caus	e(s)
To the within To the comple	(Check only one) 2 2 1	and man	ner stated.			nse number				(Month, Da	
	Zab. Signature and t	- M. W.	. 1 1		0.0	C.M.E.		Octob	er 12, 2	2009	
	30. Name and addre	ess of person who completed	d cause of death (Ite	m 23a)							
	Margarita Ko	orell MD. Assistant	Medical Exami	iner 111	Penn Street,	Baltimore	, MD 21201				
Sta		11, 20, 1011	32. Registrar's Signa	ature	acked						
Registr		CT 1 5 2009	General	ORIGIN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	e of Maryland / Dep <i>Ce</i>	ertificate of D		R	eg. No. 200	19 3462	
Physic		1. Decedent's Name <i>(First, Middle, Last)</i> ZHIJIE LIU				2. Date of Deat		3. Time of Death 12:50 Р м	
/Med Exam		4a. Facility Name (If not institution, give street and Shady Grove Adventist		4b. City, Town, or L Rock	ocation of Death		4c. County of Dea		
Funera Directo		5. Social Security Number 6. Sex 1 ☐ M 2 反	F 80 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 1	9. Bir (Co. 28, 1929	thplace (State or Foreign ountry) China	
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
e Mar 8a-f st	Director	MD Montgomery	Roo	ckville				1 XYes 2 No	
with the	I Dire	10e. Street and Number 2026 Dundee Road		10f. Zip Code 2085	50	1	0g. Citizen of What Co China	ountry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Experiment part regards and more.	by Funeral	11. Marital Status 12. Was Arme 1 Never Married 2 Married 1 TY	Decedent Ever in U.S. d Forces? es 2∑No , Give , Give or Dates:	. Was Decedent of His If Yes, specify Cuban 1 □Yes 🏖 No	panic Origin? (Sp , Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or any lajury or other traumatic event, it a Medical Exprin	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle VYS	(Giv life.	edent's Usual Occupat le kind of work done du DO NOT use retired) Housewife	tion tring most of work	ing	16b. Kind of Business.	/Industry	
nd 2	Be C	17. Father's Name (First, Middle, Last)				,	Maiden Surname)		
rylai	2	Qingwen Liu	40h Mai	Line Address (Chronton	Yuzhen		r, City or Town, State,	Zin Codo)	
Maind 2 st alth an 27 Is r		19a. Informant's Name/Relationship (Type. Print) Ao Yan (Husband)		Dundee Ro				zip Code)	
Or othe		20a. Method of Disposition 1 ☐ Burial ↑ 🛣 Cremation 3 ☐ Removal f	om State///	ematory or other place,) ;		20c. Location - City or	_	
Itim nit. Pagartmen artmen srtant: injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	// Argent C	_	10/1	-	Hanover, M NERAL HOME		
		Junge 13					ville, MD		
Physician		23a, Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	nat caused the death. Do not ele on each line. Lung Cancer	nter the mode of dying	, such as cardiac	or respiratory arn	rest,	Approximate interval Between Onset and Death	
/Medical		resulting in death)	e to (or as a consequence of):	ai luro					
68760, Cificate be executed g physician and is the burial-transit	ledical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Resultance Failure Due to (or as a consequence of): C. Due to (or as a consequence of):							
I Records, P.O. Box 68 The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	in the past 12 months?		☐ Ectopic pregnancy			23d. Date of de Month	elivery Day Year	
that the ned by detack		Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause giver	n in Part I.	23e, Did to	bacco use contribute t	o the cause of death?	
cords, w requires t s been signe should be	ed by					1 □ Ye	es 2□No 3□P	robably 4 ☑ Unknown	
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f Vita nysician: nis certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	14∑ Inpatient 2 ☐ ER/Outpati	Other	26. Place of Deat		ence 6 ☐ Other (Spe	ecify)	
on of ding Phys	on: To	27. Manner of Death 28a. [Date of Injury 28b. Time Month, Day, Year) Injury	of 28c, Injury Work?	at		ow injury occurred	,,	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be	lace of Injury - At home, farm, suilding, etc. (Specify)		es 2□No	28f. Location (S. City or Town	treet and Number or Fi n, State)	lural Route Number,	
Hospita 24 hours Funera tely fille		(Check only 2 Medical Examiner: On the	o the best of my knowledge, dea he basis of examination and/or						
Fo the within 2 Fo the somple	Medical	one) and 29b. Signature and title of certifier	manner stated.	29c. License	number	2	29d. Date signed (Mon	th, Day, Year)	
3		Diffy day, mo	•	7 000	55505		October 1	2,2009	
		30. Name and address of person who completed QUFANG CHENG,			Z-N T 7-0	וש שח	CKUIIIZ	MD	
Si 3 Regis	ate	31. Date filed (Month, Day, Year)	M.D. 9901 P. Registrar's Signature	el.	J. 102	p per per			

			State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and I rtificate of Death		ene eg. No. 200	9 34628
			Decedent's Name (First, Middle, Last)		2. Date of Death	g. 1101	3. Time of Death
	Physicia Medic		Eileen Cummins Levi		10 Month	Day 2009	8:15A [™]
	iviedic Examin		4a. Facllity Name (if not institution, give street and number)	4b. City, Town, or Location of Death	·	4c. County of Dea	
_ /			Manor Care Potomac	Potomac		Montgor	nery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		052-24-8166 1	World's Days Hours Will.	10/17/19	28 Nev	untry) V York
	and show d at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	nestion			10d. Inside City Limits
	nylan I-f sh ied a	cto					1 🕱 Yes 2 🗆 No
	e Ma r 28a notif	Sire	MD Montgomery Potomac	10f, Zip Code		0.000	
	ith th	Funeral Director		·		0g. Citizen of What Co	
	ms 2	nue	9440 New Bridge Drive, #114 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20854 Was Decedent of Hispanic Origin? (Sp		United Sta	
-	or ite	by Fi	1 ☐ Never Married 2 ☐ Married ☐ 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Š	s afte "al", (Exan			1 ☐ Yes 2X No Specify:		Specify: B	Lack
Š	hour natur lical	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business	Industry
2	n 72 an "ı Med	Ĕ	116- 1	kind of work done during most of work OO NOT use retired)	dna I	ontgomery	
7	withi giene er th , the			ctor of Headstart		ublic Scho	
2	o filed within 72 hours after death with the Maryland tal Hygiene. A other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Be c	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, M	aiden Surname)	
<u> </u>	d be Ment arked	2	Leonard Cummins	Anasta	sia Bon		
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. It of Health and Mental Hyglene. Or them 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Maili	ng Address (Street and Number or Rui	al Route Number, (City or Town, State, Zi	p Code)
			Travis Levi / Son 7915	Eastern Avenue, #	909, Sil	ver Spring	MD 20910
ore	of H of H iter		20a. Method of Disposition 20b. Place of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, cre	motory or other place)		20c. Location - City or	Town, State
baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce.		TES Bullar 2 - Cleriation 3 - Removal non-State	Heaven Cem. 10/9	/2009	Silver Spr	ing, MD
ä	permit. Departi Import any inj		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility MC	Guire Fu	neral Serv	ice, Inc.
<u>n</u>	20 = # 9	G 78		7400 Georg i a Avenu			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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	Medical		resulting in death) a. Due to (or as a consequence of):	CCION			13110111
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	rte be executed hysician and he burial-transii	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
3	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dici	d				
200	rtifice ing p	Physician/Me	IF FEMALE:				
×	th ce ttend or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of de	
POX	deat the at	/sic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year
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VITAL K	cian	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)		
> [Physical this call directions	요	1 Inpatient 2 ER/Outpatie			nce 6 Other (Spec	cify)
ָ ס	ing l	ate	1 🔀 Natural 5 ☐ Pending (Month, Day, Year) injury	work?	28d. Describe hov	v injury occurred	
VISION OF	death death death tor: /	tiţi	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Oof Leading Other		I Davida Musebas
<u> </u>	or A after Direc in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	City or Town,	eet and Numb e r or Ru State)	rai Houte Number,
ָ ב	pital ours eral l filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place a	ad due to the caus	ale) and manner as et	eted
:	To the Hospital or Attending Physician: The law requires that the death certifica within 24 herous after death. To the Funeural Director. After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inves	tigation, in my opinion, death occurred a	t the time, date and	I place, and due to the	cause(s) and manner stated.
	vithin orthe	≥	29b. Signature and title of dentifier)	29c. License number		d. Date signed (Mont	
	اگا		* Atali-	119609		0.04.2	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)			
			Dr. Raman Tuli, 10810 Darnestown Roa		thersburg	g, MD 208	78
	Stat	e	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
	Registra		OCT 15 2009 Desur A. Ja	Red			

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AMEND ITEM#5perFH,G898,12/8/09,WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:30 a M October 08, 2009 David B. Levey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Alfred House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 094-18-8388 094-16-8388 Funeral Days Hours Months 1 M 2 □ F New York November 21, 1924 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20906 3330 North Leisure World Blvd., Apt. 717 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced WII Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Jewelry. Jewelry Store Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be. Department of Health and Mental h. Important: if them 27 is markany inlury or other any inlury or other. Be Bessie Klass ဥ Alan Levey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3330 North Leisure World Blvd., Apt. 717, Silver Spring, MD20906 Marjorie Levey - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Bemoval from State Arlington National Cemetery 12/04/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Libensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death accident acute Repersonas enla Immediate Cause (Final Way? **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): year Examiner unelletins Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Conesno Vesenda Disen as lesioselerotic or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Box 68760, arterioselerosis Physician/Medical phy the as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) To the I within 24 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 15 2009

29b. Signature and title of certifier

Oliver J.

18111 Prince Phillip Dr; Olney, MD Lawless, M.D. 32/Registrar's Signature

aucess

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

+1

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2009

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		•	For State Registrar	State of Ma	,	partment of F ertificate of L		, 0	ene eg. No. 200	9 34631
	Physicia	ın/	1. Decedent's Name (First, Middle, I	·	_			2. Date of Death)	3. Time of Death
,	Medic	al	4a. Facility Name (if not institution, g	Kwan I1	Lee	4h City Town or	Location of Death	October	r 14, 2009	7:50 ам
j	Examin	er	Randolph Hill N				heaton		4c. County of Deat	gomery
	Funeral				e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	g, Birt	thplace (State or Foreign
	Director		212-96-8090 Usual Residence of Decedent	TAZ M Z C F	94 Yrs.			June 11,	1915	Korea
	and show	ro	10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Mary 28a-f otifie	Director	Maryland Mon	gomery			Silver Spr	ing		1 ☐ Yes 2 🗷 No
	ith the	ral D	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	
	eath w	Funeral	1802 Alber	12. Was Decedent E	ever in U.S. 13	. Was Decedent of Hi	20902 spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	rican Indian.
98	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ρ	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 X		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto	Rican, etc.)	Black, White	
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21	iled withi Il Hygiene I other th vent, the		7			Mercl			Convenier	ce Store
Maryland 21215-0036	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Las	t) Chon Man Lee			18. Mother's Nam	e (First, Middle, Ma	aiden Surname) ukr	1
aryl	should be fil n and Mental r is marked of raumatic ever		19a. Informant's Name/Relationship		19b. Ma	iling Address (Street a	and Number or Run	al Route Number (City or Town, State, Zip	Code)
ž,	and 2 sh Health a tem 27 is ther trau		Donald S. Lee			-			Maryland 209	
ore	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 X Burial 2 Cremation 3	☐ Removal from State	20b. Place of Dis cemetery, cr	oosition (Name of ematory or other plac	e)	Date 2	20c. Location - City or	Town, State
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Ba	permi Depar Impo any ir	ļ,	21. Signature of Funeral Service Lic	we	1	22. Name and Addres Iines-Rinald L1800 New Har	i Funeral H	ome, Inc. nue, Silve	r Spring, Mar	yland 20904
			23a. Part 1. Enter the disease, or conshock, or heart failure. List onl	emplications that caused y one cause on each line	the death. Do not e	nter the mode of dying	g, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death
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_	n #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of):					
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8760	tificate ng phy as the		IF FEMALE:							
9X 68	ath certificate be executed attending physician and for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	у		23d. Date of del Month	ivery Day Year
P.O. Box	he dea y the a ched f	hysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time or death 5	☐ Other (specify)			Monar	Day Tour
P.0	es that the dec signed by the a be detached t	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds,	requires been sig	ted	Congestive Heart	Failure				1 🗆 Yes	s 2 No 3 Pr	obably 4 🗷 Unknown
Division of Vital Records,	has bo	Completed	Dementia					24a. Was an autopsy perform	prior to c	opsy findings available completion of cause of
Œ Œ	in; The ifficate or, pag		25. Was case referred to medical			26 Pla	ace of Death (Chec	1 Yes 2		2 🗆 No
Vita	nysicia nis cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpat	Othe	ar.		nce 6 Other (Speci	ify)
οί	ling Pt		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injui (Month, Day	y 28b. Time (, Year) injury	work	?	28d. Describe how	v injury occurred	
sior	Attend death ctor: / cy the f	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	t be	ry - At home, farm, s		Yes 2 ☐ No	28f Location (Stre	eet and Number or Rur	al Route Number
<u>N</u>	tal or / rs after al Dire		4 ☐ Homicide determin	building, etc		•	Į.	City or Town,		
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2 Medical Exa	hysician: To the best of ominer: On the basis of exurse Practioner: To the	kamination and/or inve	estigation, in my opinio	n, death occurred a	t the time, date and	place, and due to the o	ause(s) and manner stated.
	To th To th comp		29b. Signature and title of certifier	n n	17	29c. License			d. Date signed (Month	
	4		alon of	Loga	Day	<u> </u>	D52261		October 14,	2009
	,		30. Name and address of person what Alan R. Segal, I				Marvl and	20906		
	Stat	e	31. Date filed (Month Pay, Year)		r's Signature		, rai y i aiid	20 700		
	Registra	ar	061 19 2	UUT CERSON	1 p. 19	ale and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 34631 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** Kris Alan Mowery 10829AM ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1**X** M 2□ F Months Days Hours Min 569-23-8292 46 26, 1963 Director Apr. Japan Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppartment of Health and Mental Hygiens. In opportant; if item 7 is marked other than "natural" or items 23a or 28a-f show Important; if item 7 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Phadical Examinat nust be notified at Director 1⊠Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12614 Kilbourne Lane 20715 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🔼 No Completed by Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Musician Bands 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Arnold Mowery Phyllis Mae Thrash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Arnold Mowery / father 12614 Kilbourne Lane Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burlal 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10/10/2009 | Baltimore, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UPPER GAGIRDINIUSIMAL BLEED SEVERE **Physician** /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner O AGULOPATHY Due to (or as a consequence of) physician a the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 10 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation iours after death. neral Director; Af ifiled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Division of Vital Records,

Hospital or Attending

Baltimore, Maryland 21215-0036

Pages 1

Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

State Registrar

completely

within 2 To the 1

31. Date filed (Month, Day, Year)

AZEE

29b. Signature and title of certifier

(Check only

ABIDUM 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

8118 GOOD LUCK ROAD LANHAM, NO 30706 Back

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year October **Physician** ğ 8:20 РМ John James McGroarty /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 78 30, 1931 Pennsylvania 178-22-3410 Director Apr. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or intems 25a or 28a-f show ury or other traumatic event, he Redical Exeminer must be notified it. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Funeral Director Riverdale MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20737 USA 6602 Freeport St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: 1952-60 Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Police Elementary/Secondary (0-12) College (1-4or 5+) Washington, D.C. Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John B. McGroarty Mary Gabel မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Riverdale, MD 20737 6602 Freeport St. Alice J. McGroarty / wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or c once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 10/14/2009 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final **Physician** reaction to disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Aner this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 2 NO 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 inpatient Certification: To 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2. one and manner stated 29d. Date signed (Month, Day, Year) 2170 30. Name and address of person wi cause of death (Item 23a) (Type, Print) Postury Site MARCO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct 7, 2009 Physician/ 11:28 AM Marie McNeil Jessie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Month Day, 1932 Months Hours 1 M 2XX Washington DC Director 577 40 5882 Usual Residence of Decedent shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🟋 No Prince George's Clinton Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20735 United States 7520 Surratts Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 o Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Fendel Gray Grace Lee Pumphrey 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 12533 Woodstock Drive, East, Upper Maroboro, MD 19a. Informant's Name/Relationship (Type, Print)
Christine McNeil (Daughter) 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 0¢t 12 pat 2009 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Epihany Episcopal Cemetery Forestville, MD 21. Signat y of Fyneral Ser y e Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCEN Physician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): physician a s the burial. Physician/Medical P.O. Box 68760 as attending (IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 Yoo Month Day Year Pregnant at time of death the g 🗌 Unknown رهد nas been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 No 1 Yes Hospital or Attending Physician: ours after death.

eral Director, After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **5**00 ျ 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

81, Date filed (Month Day, 3 2009

W. ILIAM

11751 Civensitu RD. Fort WARN, upt us Mpmy and 32. Ingistrar's Signature Guerra

Certifying Nurse Practioner: To the Sest of My knowledge, de

prina un

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D35206

d at the time: daw and clane, and due to the equiets) and manner as state

Registrar

pleted

within 2 To the

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34634 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Carmen Pladevall de Mercado <u>7:00</u> a^M 2009 October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Genesis Spa Creek Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye Jan. 13, 5. Social Security Number 7. Age (In yrs. last birthday, Year) 1911 1 ☐ M 2 🕱 F Argentina 214-51-3164 98 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Anne Arundel Annapolis 1 ☑ Yes 2 ☐ No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 35 Milkshake Lane 21403 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1♥Yes 2□No Specify: Argentinean Hispanic 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joaquina Garcia Jose Pladevall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 141 Berrywood Drive Severna Park, MD 21146 George Mercado / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 08, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, INC. Baltimore, MD 4 □ Donation 5 □ Other (Specify) 2009 P.A. Severna Park Funeral House Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licenses Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mentall Hygiens in Internative income are used in 100 marked by the Internative in Int

/Medical

10a State

Director

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Physician/Medical Examiner burial-tran attending pl for use as t ours after death.

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

þ Be Completed Medical Certification: To

	Due to (or as a consequ	ence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	b									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d	23d. Date of delivery Month Day Year								
Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the underlying o	cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available					
25. Was case referred to medical examiner?	Hospital:			autopsy performed? 1 □Yes 2 → ath <i>(Check only one)</i>	No 1 □Yes 2 □No					
1 ☐ Yes 2 ☐ Y	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 D 28b. Time of Injury M	OA Oursing I 28c. Injury at Work? 1 Yes 2 No	dome 5 ☐ Residence 28d. Describe how in						
3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor	y, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)					
	rsician: To the best of my kno				e(s) and manner as stated.					

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

10/7/2003 Brint Donah Drue Clerke, Mrs 2/6/9 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) 2108

31. Date filed (Month, Day, Year)

09

and manner stated

within 24 hours at To the Funeral D completely filled i

one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Morris ames /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 12, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In a wedless Event in the traumatic event, In a wedless in the source. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1**Y** Yes 2 □ No MARYLAND TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31132 HUNTEMANS ALLEY 21625 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify. þ Specify: WHITE 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 MECHANIC PLUMBING Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM MORRIS ANNIE SWARTZ 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES MORRIS, JR./SON 11994 CORDOVA RD. CORDOVA, MD 21625 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State GREENMOUNT CEMETERY : OCT. 10, 2009 4 ☐ Donation 5 ☐ Other (Specify) HILLSBORO, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 200 SOUTH HARRISON ST, EASTON, MD 21601 JOHN R. MERLERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner 1 Rumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examines Due to (or as a conse mence of) Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ☑Yes 2☐No 3☐Probably 4☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 12 Inpatient Certification: To 1 Tes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 1 ☐ Yes 2 🗌 No 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mos - Undnis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 RK MSar 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

P.0.

Division of Vital Records,

09-08117 Froylan Mendoza Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 34636

,		For State	,	Certifica	ate of	Death				eg. No.		3. Time of De	340
Physician edical Examine	/ 1.	Decedent's Name (First, Middl Froylan	Mendoza	Mend					Date of Dea Month October 1	Day 9, 2009	Year ounty of De	1340 hr	
	4:	a. Facility Name (if not institution 126 Janwall Street	on, give street and number)		41	o. City, Town, or L Annapolis	ocation of			Ann	e Arund	del	
Funeral Director		Social Security Number		e (In yrs. last birt 28	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	24Hrs. 8 Min.		/198	IFC	Birthplace (State oreignMexic Country)	or O
executed permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	edical Examiner To Be Completed by Funeral Director	126 Janwall Street Social Security Number NONE Sual Residence of Decedent Oa. State MD Anne Oe. Street and Number 1 000 Madison 1 Marital Status 1 X Never Married 2 M 3 Widowed 4 Di 15. Decedent's Education (Special Security Secondary (0-12) 1 2 17. Father's Name (First, Middle Bernardo Me 19a. Informant's Name/Relation 1 X Burial 2 Crematic 1 X Donation 5 Other (1) 21. Signature of Funeral Servic 228. Part 1. Enter the disease, failure. List only one caus 1 Immediate Cause (Final diseasor condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Pissease or injury that initiated events resulting in death) Las	Arundel Street Arundel Street Arundel 12. Was Deceden Armed Forces If Yes, Give Year or Dates: ecify only highest grade co College (1-4 or Dates) Alcoho Specify: Complications that causes see on each line. See on each line. See on Each line	t Ever in U.S. 2 X No mpleted) 16a. 20b. Place creme San 1 intoxi nsequence of): nsequence of):	or Location of Location of Location of Location of Location of Location of Location of Disposatory or other of Location of Loc	If Under 1 Year Months Days 10f. Zip Code 2140 s Decedent of Hisses, specify Cuban, Yes 2 No I's Usual Occupations of working life. Loberer Address (Street Madis Sition (Name of center place) O Siniy Name and Address HILLP D 241 Col The mode of dying	Hours panic Origin Mexamination (Give known to Month of Signature) and the stand Num on Signature Min. In? (Spece Puerto Ri i Car ii C	9/15 ify Yes or Nocan, etc.) if ik done if a Metal Route Not 4D Date 29/20 I FUN 1 vd S respiratory	inth (MM/DD// 198 10g. Citizen Me lo- 14 Sp 16b. Kinn Co o, Maiden St endo Z umber, City O Ann 20c. Lo O SERAL Si I V A arrest, shoc	n of What of Exic. Race - A White, e pecify: d of Busin onsturname) a or Town, apol	Birthplace (State reign Mexic Country) 10d. Inside (1 X Yes) 10d. Inside (1 X Yes) Country? O merican Indian, B tc. White ess/Industry ruction State, Zip Code) is _ Md _ 2 ity or Town, State CVICE P TOWN Between D	City Limits 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ysician/	Part II. Other significant con	unknown 9 Unknown unknown 9 Unknown unknown 9 Unknown unditions contributing to de	t at time of death	2 F 5 C				23e. D 1 24a. V a	Yes 2 Vas an utopsy erformed?	Month use contrit No 3 24b. W p d	Day oute to the cause Probably 4 Vere autopsy finding to completion eath?	Unknown ngs available of cause of
tal Rec ciant. The la certificate h.	Com	25. Was case referred to med	tical			26.Pla	ce of Death	h (Check		es 2 N	0 1	✓ Yes 2	2 No
Vital ysicians his certi director	To Be	examiner?	11 11 1		₹/Outpatie	nt 3 DOA	Other ₄	Nursir	ng Home 5			Other: Scene	
n of Jing Ph. After t	on: T	27. Manner of Death	28a. Date of (Month, D	ay,Year)	Bb. Time o		jury at Wo		unk	ribe how inju	ury occurr	eu	
rision r Attene er death irector: n by the	Certification:	2 Accident Ir	FU IU		e, farm, st	reet, factory, office			28f. Locati	ion (Street a	and Number	er or Rural Route Annapol:	Number, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	al Certi	4 Homicide	g Physician: To the best of Examiner: On the basis of	reside		curred at the time,	date and p	place, and	due to the	cause(s) ar	nd manner	as stated.	
To the within Comple	Medical		and mariner sta	ted.	Of IIIVesti	29c. Lice	ense numbe	er	CME	29d.	Date sign	ed (Month, Day,)	'ear)
		30. Name and address of per		of death (Hem 23	3a)	111 Penn		Raltimo	re MD 2				
		Theodore M. King,		nt Medical Ex		_	oneet, E						
S Regis	tate trai	31. Date filed (Month, Day, Ye	3 2009 Dena	m B.	40	R.J.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 10:07 A Mabel Irene Martin October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Mennonite Fellowship Home Hagerstown Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 24, 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2 🔀 F Days Hours 1923 213-82-8081 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 K No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12349 Huyett Lane 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amos Tobias Showalter Rhoda Mae Shank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Richard Martin Jr. (Son) 8142 Nyesville Road Chambersburg, PA 17202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pinesburg Mennonite Church Cemetery 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct.20,2009 Williamsport, Maryland 22. Name and Address of Facility 21. Signature of Funeral sborne Funeral Home P.A. 425 S. Conococheague St Williamsport, Maryland 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cel Due to (or as a consequence of): ronce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cer Teri Due to (a sa a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 Vo 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? Yes No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) H5515 Tec Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Peath 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760. been signed by the should be detached Division of Vital Records, page 2 s certificate Attending Physician: funeral director, this After death. To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

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Important: If any injury o once,

Physician

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Certification; To

Medical

29a, Certifier

31. Date filed (Month

29b. Signature and title of certifie

an

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

546-3

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 Wara ontl mo

32. Redistrar's Signature

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Willst.

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		Re	eg. No. 2009	34638
Physic		Decedent's Name (First, Midda	_{le, Last)} Ngo Che I	Ng			2. Date of Death Month October		3. Time of Death 9:44 am
/Medi Exami	ner	4a. Facility Name (If not institutio Holy Cross Ho 5. Social Security Number	spital	e (In yrs. last birthday	Silve	Location of Death r Spring If Under 24 Hrs.		4c. County of Death Montgome	lace (State or Foreign
Funeral Director		579-72-6055 Usual Residence of Decedent	1 M 2 □ F	72 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 25,	1937 Court	hina
Maryland -f show	tor	10a. State 10b. County MD Mon	tgomery	10c. City, Town or L		lver Spr	ing	1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 28a st be roli	Funeral Director	10e. Street and Number 12412 Denley			10f. Zip Code	20906	10	og. Citizen of What Coun	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	If Yes, Give	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify:	
IZ I 3-UU30 ithin 72 hours aff ne. han "natural", or Model Etumi	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5	(Give	edent's Usual Occupa e kind of work done of DO NOT use retired	during most of work l)		16b. Kind of Business/Ind	dustry
filed within Hygiene. other than " ent, tre Me	Be Co	17. Father's Name (First, Middle,	Last)		Che	-	ne (First, Middle, M		и
should be ind Mental marked c	To B		You Moy Ng				Mee_	Jin Lee	
Mar 12 sho h and 7 Is ma trauma		19a. Informant's Name/Relations			,			, City or Town, State, Zip Ting, Marylo	
Dartimore, Maryland ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Vim Sheung Ng 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 21. Signature of Funeral Service	3 ☐ Removal from State	20b. Place of Disp cemetery, cre Gate of	nosition (Name of tematory or other place Heaven Ce. 22. Name and Address	m. 10/1:	Date 5/2009 nes-Rina	20c. Location - City or To Silver Sprii Edi Funeral Silver Spriv	ng, MD Home, Inc.
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate and cer	edical Examiner	23a. vart1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Muoca Due to (or as b. Huper Due to (or as	ne. rdial Infa a consequence of):	rction			ılar Diseası	Approximate interval Between Onset and Death
the death certific y the aftending priched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
w requires that the despension of the despension of the despension of the should be detached	þ	Part II. Other significant condit	ions contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		bacco use contribute to t es 2 □ No 3 □ Pro	
VITAI HECOIDS, ician: The law requires tertificate has been signe ector, page 2 should be o	Completed							med? death? 2 Mo 1 □ Yes	opsy findings available impletion of cause of
ysiciar ysiciar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No	Hospital:	ent 2 🕅 ER/Outpati	ent 3 DOA Oth	or:	ith <i>(Check only on</i> lome 5 ☐ Reside	ence 6 ⊡Other <i>(Speci</i>	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; T	Z L Accident	igation	y, Year) Injury	M 1□	yat k? Yes 2∐No		ow injury occurred	
DIVIS		4 Homicide determ	mined 28e. Place of my building, et	ury - At home, farm, s c. <i>(Specify)</i>			City or Tow		
e Host 124 hol e Fune letely fi	Medical	29a. Certifier 1 🔏 Certify (Check only 2 Medical one)	ing Physicien: To the best i Examiner: On the basis of and manner st	f examination and/or	investigation, in my o	opinion, death occu	urred at the time, o	date and place, and due	to the cause(s)
To the comp	Me	29b. Signature and title of certifi	Then		29c. Licens P 2	e number -434 8	. 2	29d. Date signed (Month)	
		30. Name and address of person	Gov fferm.	leath (Item 23a) (Type A M My) ar's Signature		t Glen R	d., Silv	er Spring,	MD 20910
St Regist	ate trar	31. Date filed (Month, Day, Year	2009 Jenera	a A. La	Med.				

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	iaryiand / Depa Cei	rtificate of L			g. No. 2000	34639
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Faye Wilson Parkinson				Month October	Day 2009	11:50 A M
	Examin		4a. Facility Name (If not institution, give street and number Fairfield Nursing Home	7)		Location of Death ownsville	9	4c. County of Dear Anne	Arundel
	Funeral Director		263-26-3602 ¹□м XXF	ge (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 13	Year) 9. Bir Co	thplace (State or Foreign ountry) Florida
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel	10c. City, Town or Lo	Severna	Park			10d. Inside City Limits 1 ☐ Yes 2X No
	h with the	al Director	10e. Street and Number 204 Balsam Tree Court		10f. Zip Code	21146	10	Og. Citizen of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is it is an example any injury or other traumatic event, It is it is a less nit or install to a collicit and once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Deceden Armed Forces 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates]No	Was Decedent of Hi If Yes, specify Cuba 1 □Yes 211410	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
Maryland 21215-0036	ithin 72 hou ne. han "natura Na Jiral	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of work)	ing	16b. Kind of Business Educati	·
and z	d be filed w ental Hygie ked other ti c event, IL	Be	17. Father's Name (First, Middle, Last) Albert C. Whitmore	rielle	entary Sch	18. Mother's Name		faiden Surname)	OII
Maryı	d 2 should be the and Mental the and Mental is marked of traumatic evertical traumatic evertical traumatic evertical is a should be the and th	우	19a. Informant's Name/Relationship (Type. Print) Glenn Parkinson/son	l l	ng Address (Street &			City or Town, State, Park, MD	Zip Code) 21146
ď	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	osition (Name of matory or other plac	e)	Date 2	20c. Location - City or Baltimore,	Town, State
Balti	permit. I Departm Importa any inju		21. Signatur Finer Syrvice Licensee	//	2. Name and Addres	U.		aylor Fune , Annapoli	ral Home s, MD 21401
Gay.	Physician /Medical		regulting in death)	ed the death. Do not ent line. - STHOE Is a consequence of):		g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death YEARS
	rificate be executed rig physician and as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	is a consequence of):					
O. Box 68	the death certificat the attending phy ched for use as the	Physician/Medical		2 Fetal death 3 [at time of death 5 [☐ Ectopic pregnanc ☐ Other (specify) _	,	- 201	23d. Date of de Month	elivery Day Year
ds, r.	uires that the de n signed by the a Id be detached f	ρ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause giv	en in Part I.	23e. Did tot		to the cause of death? Probably 4 Unknown
al Reco	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. The same safter death recompletely funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	Completed					24a. Was a autops perforr	y prior to ned? death?	autopsy findings available completion of cause of s 2 \Box
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	on: To Be	27. Manner of Death 28a. Date of Ir	ntient 2 ER/Outpatie	of 28c. Injur Worl	4 Nursing H	ome 5 🗆 Reside	e) ence 6 Other (Sp ow injury occurred	ecify)
Divisio	I or Attendi after death. Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of	njury - At home, farm, sti etc. (Specify)		Yes 2 □No	28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
	e Hospital 124 hours a e Funeral letely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination and/or in	th occurred at the ti nvestigation, in my o	me, date and place pinion, death occu	, and due to the c rred at the time, d	cause(s) and manner late and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of bertifier		29c. Licens			9d. Date signed (Mor	
7.	1 10		30. Name and address of person who completed cause of	f death (Item 23a) (Type,	, Print)	100753	1 1 cA /	hnaplis M	0.24/01
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Division of Vital Records,

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32. Régistrar's Signature

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Department of Health and M State Registrar Certificate of Death	Reg	g. No. 2009 31.CL					
	Physici		Decedent's Name (First, Middle, Last) RUTH ALICE PROCTOR	2. Date of Death Month OCTOBER	Day Year 2009 11:40 P M					
-	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death					
and F			6001 Muncaster Mill RdCasey House Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Montgomery 9. Birthplace (State or Foreign					
	Funeral Director		308-30-4448 1 M 2 F 78 1 North Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Oct. 14	Year) Country) 1930 Indiana					
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show that it is Modical Evaninar must be notified at	ctor	10a. State 10b. County 10c. City, Town or Location Woodbine		10d. Inside City Limits 1 □ Yes 2 No					
		ral Director	10e. Street and Number 3211 Hayloft Court 21797-7940		g. Citizen of What Country? United States					
036		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto if Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
5-0		Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working the complete of the complete o	ng 1	6b. Kind of Business/Industry					
112	within iene. • than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Extension Director		State Government					
þ	~ = 0 W	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	aiden Surname)					
ylaı		To E	Leland H. Carson Lula		rooks					
, Maryland 21215-0036	d 2 s th all 7 ls trau		19a. Informant's Name/Relationship (Type. Print) Frank B. Proctor / Husband 19b. Mailing Address (Street and Number or Rura 3211 Hayloft Court, Wo							
Baltimore,			1 ■ Burial 2 □ Cremation 3 □ Removal from State		0c. Location - City or Town, State Poplar Springs, Md.					
Baltii	permit. Page Department of Important: If any injury of once.		21. Signiful of Funer Service 10.17 21. Signiful of Funer Service 10.17 22. Name and Address of Facility Muriel H. Barber F. P. O. Box 5038, I	Tuneral 1	Home					
	The law requires that the death certificate be executed as being signed by the attending physician and are been signed by the attending physician and be detached for use as the burtal-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							
P.O. Box 687		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown	"	23d. Date of delivery Month Day Year					
	w requires that been signed should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death? s 2 ☐ No 3 ☐ Probably 4 🕱 Unknown					
Vital Records,		e Completed	25. Was case referred to medical 26, Place of Death	24a. Was an autopsy perform	prior to completion of cause of death? No 1 Yes 2 No					
of	di is	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	□ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 ★ Other (Special Residence 6 ■ Other (
Division	i di al	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	ne Hospital n 24 hours a ne Funeral E	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.							
	To the within 2. To the complet	Me	29b. Signature and title of certifier J. Wuch heu, M.) 29c. License number b63748	29	Od. Date signed (Month, Day, Year) October 8, 2009					
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road, F	Rockville	e, Md. 20855					
	Sta Registr		31. Date filed (Month, Day, Year) 09 2009 Lenwa A. Janes							

09-08176										
Virginia Powers										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Certificate of	Death	Reg. No. 20	<u>09 3461</u>					
Physician/ Medical Examiner		1. Decedent's Name (First, Middle,Last) Virginia Dorette	Powers		2. Date of Death Month Day Year October 21, 2009	3. Time of Death 1525 hrs					
A TO		4a. Facility Name (if not institution, give street and num 11901 Indian Lane		b. City, Town, or Location of Death Hagerstown		h					
Funeral Director		215-90-4181 1_M 2XF	. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Mir	Forei						
w any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on		10d. Inside City Limits 1 Yes 2 X No					
daryland 28a-f show 1 at once.	Director	MD Washington 10e. Street and Number	Hagerstown	10f. Zip Code	10g. Citizen of What Cou						
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11901 Indian Lane 11. Marital Status 12. Was Dece	dent Ever in U.S. 13. Was	21742 s Decedent of Hispanic Origin? (S		rican Indian, Black,					
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed For 1 Yes 3 Widowed 4 X Divorced If Yes, Give Year	2 X No	es, specify Cuban, Mexican, Puerto Yes 2 No specify:	o Rican, etc.) White, etc. Specify: wh	ite					
2 hours af "natural" Examine	ted by	15. Decedent's Education (Specify only highest grades Elementary/Secondary (0-12) College (1-4)	completed) 16a. Decedent	t's Usual Occupation (Give kind of ost of working life, DO NOT use re	work done 16b. Kind of Business						
e, MD 21215-0036 I and 2 should be filed within 72 hours Health and Mental Hygiene. Fitem 27 is marked other than "naturer traumatic event, the Medical Exam	completed	4 17. Father's Name (First, Middle, Last)	invest		state e (First, Middle, Maiden Surname)						
O 3 2 2 2 5	o Be C	Bonifacio S. Zamora 19a. Informant's Name/Relationship (Type, Print)	19b Mailing		Ellen Schenzel Rural Route Number, City or Town, Stat	e. Zip Codell 7 2 2 7					
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is n	2	Traute Ellen Hess 20a. Method of Discosition	306	Verdier St. P.(lto, PA					
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Met Important: If iten 27 is man injury or other traumatic ev		1 X Burial 2 Cremation 3 X Removal from Donation 5 Other Specify:	n State crematory or oth	ner place)	26/2009 Waynesbo	·					
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Licensee		ame and Address of Facility G. S. Broad St.	rove-Bowersox Fune Waynesboro, PA 1						
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and									
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiomegaly with biventricular hypertrophy and Due to (or as a consequence of): dilatation									
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	f								
scuted and transit	al Examin										
60, ate be exe obysician ne burial -	Medical	IF FEMALE: 23c. If yes, or	23a,27,permE,	g897 11/23/09 3	TT 23d. Date of delive	ery					
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	nt at time of death 5 Oth	tal death 3 Ectopic pregriher (Specify)	nancy Month	Day Year					
P.O. B that the d ned by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca										
Division of Vital Records, P.O. Box 68760, To the Ilospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit	Completed										
I Rec	e Con	25. Was case referred to medical		26.Place of Death (Chec	1 🗸 Yes 2 No 1 🗸	Yes 2 No					
f Vita Physicia er this ce ral direc	To B	TIV TES ZI INO	patient 2 ER/Outpatient f Injury 28b. Time of I		sing Home 5 Residence 6 Oth Oth 28d. Describe how injury occurred	er: Scene					
tending death. etor: Aft	ation:	1 X Natural 5 Pending (Month, 2 Accident Investigation		1 Yes 2 No							
Divis	Certification:	Suicide Could not be determined (Specify)	of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Street and Number or lor Town, State)	Rural Route Number, City					
o the Hos ithin 24 h o the Fun mpletely	Medical (29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or investigat	rred at the time, date and place, at tion, in my opinion, death occurred	nd due to the cause(s) and manner as st if at the time, date and place, and due to	ated. the cause(s)					
F 3 F 3	Me	29b. Signature and title of certifier		29c. License number O.C.M.E.	29d. Date signed (A October 22, 20	• • • • • • • • • • • • • • • • • • • •					
		30. Name and address of person who completed cause									
		Ana Rubio MD. Assistant Medical E	xaminer 111 Penn S	Street, Baltimore, MD 212	01						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Emmert Rice, III 7:15 October 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Beltsville 11333 Frances Drive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Country) Maryland 55 Months Days Hours Min Month, Day, Ye. Director 220-60-5287 Usual Residence of Decedent or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Calvert Owings 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9040 Marcellas Drive 20736 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Senior Tech Representitive Xerox Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Emmert Rice, Jr. Gladys Louise Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Gladys Rice/Mother 11333 Frances Drive, Beltsville, MD 20705 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KBurial 2. Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 10/09/2009 Clinton, Maryland 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or shock, or heart failure List of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death epsis Physician/ disease or condition Medical resulting in death) Examiner ta: lura Sequentially list conditions, Examine if any, leading to immediate
The Uncertainty
Cause (Disease or iinjury Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical P.O. Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death been signed by the should be detached g Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No certificate 2 No 1 Ves Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗷 No 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: eral Director: After filled in by the funer 1 Z Natural 5 Pending death. 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0066940

CH 5

Registrar
DHMH 17 Rev 7/2009

Road

Queensbury

Riverdale, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4404

Date filed (Month, Day,

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State o		d / Depa		of H	ealth		lental Hyg			31.4	s I. I.
		Decedent's Name (First, Middle,	Last)						T	2. Date of Deat	th		3. Time of I	Jeath
Physicia /Medic		Dolly	Elaine l	Richards	son					Oct 10	, 2009	Teal	11:31	Ам
Examin		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death				4c. County of Death Prince George's			
		Prince George					ever.		Od Uro I	0.0-1(0:4)			_	Finite
Funeral Director		578 52 0829	5. Sex 1 □ M 2 F	7. Age (In yrs.)	Ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth Jan 17,	1939	Mar Mar	place (State or yland	roreign
land	tor	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	y Limits
Mary -f sh		Maryland Charle			Cob	b Isla	and						1 □Yes	2 XX
n the	Director	10e. Street and Number				10f. Zip				1	0g. Citizen	of What Cou	ıntry?	
eath with the Marylar s 23a or 28a-f show must be rediffed at	by Funeral C	18116 Piedm	ont Driv	e		20625					Unit	ed St	ates	
r dea er mi		11. Marital Status	Armed Fo	edent Ever in U. orces?	S. 13.	Was Deced	ent of Hi	spanic Or	igin? (Spen, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White		
s afte		1 □ Never Married 2 □ Marrie	If Yes. Gi	NeXXX			No	Specify.			Spe	cify:	White	
hour tural	ed	3 Widowed 4 ☐ Divorced 15. Decedent's	Year or D	ates:	16a. Dece	dent's Usua		ation			16b. Kind o			
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinal must be notified at	To Be Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	1-4or 5 ()	(Give	kind of wor DO NOT us	k done d e retired,	luring mos)	st of worki	ng			,	
d with		12	College (1-401 0+)		Layou	t Pr					inting		
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permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental hygiene. Importent: If item 27 is marked other than "naturany injury or other traumetic event, I'm Medical once.		19a. Informant's Name/Relationshi Molly Deagle (I	Daughter)		4510	6 Dea	gle'	s Boa	atyar	d Road,	Tall	Timbe	ers, MD	20690
s 1 ar of Hea item (20a. Method of Disposition	_	20b. F	Place of Dispo emetery, crer	sition (Nam	e of	١ (۵		Date	20c. Location	on - City or T	Town, State	
Page nent c ant: If		1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp							ct 16	, 2009	Suitla	and, M	laryland	i
epartr epartr porte ny inju		21. Signature of Funeral Service L	ice/see	A 1-10						Funeral				
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eath certificate attending phys for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregna birth 2 Teta mant et time of a	I death 3	☐ Ectopic pr ☐ Other (sp		4			23d.	Date of del Month		/ear
w requires that the d been signed by the should be detached	þ	Part II. Other significent condition	ns contributing to d	eath but not res	ulting in the u	inderlying ca	ause give	en in Part	l.		bacco use d		the cause of d	
in: The law re ificate has bed or, page 2 sho	Completed	25. Was case referred to medical						ac Nie		24a. Was a autop perfor 1 □ Yes	med? 2 MNo	prior to death?	itopsy findings completion of c	available ause of
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ng Ph fter th	n:T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date	•	28b. Time o		8c. Injury Work	y at		28d. Describe h				
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical Certification: To	2 Accident investige 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	e of Injury - At ho ling, etc. <i>(Speci</i>	ome, farm, sti	M reet, factory	1 🗆 '	Yes 2□]No	28f. Location (S City or Tow	Street and N vn, State)	umber or Ru	ural Route Num	ber,
e Hospite 24 hours e Funerel	dical C		p Physiclan: To the exeminer: On the b and man											;)
To th within To th comp	Me	29b. Signature and title of certifier	CB	Vi	m()	0	21	e number	7/		29d. Date si	gned (Mont	h, Day, Year)	
27		30. Name and address of person v						Cl	1	MD				
Sta	te	Willie C. Bla 31. Date filed (Month, Day, Year)	32 F	Renietrar's Signs	ature			cnev	erly,	20 עוייו	785			
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Roger Dale Robin		- For State	ate o	f Maryla		epartme Ce <i>rtifica</i>				Menta	al Hygie		g. No.	20	09 :	3461
Physicia	n/	Registrar 1. Decedent's Name (First, Midd		1							М	ate of Death	Day	Year	3. Time of Do	
Medical Examir		Roger Dal						h City To	um or l	ocation of		ctober 2,		unty of Dea		
		4a. Facility Name (if not institution Frederick Memorial H	-		mber)			Freder		.ocation of	Death			derick		
Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birt	hday)	If Under		If Under		Date of Birt	h(MM/DD/	Fore	irthplace (State	
Director		171-40-9800	1 X N	и 2_F		59	Yrs	Months.	Days	Hours	Min. N	ov. 20	0, 19	49	ountry Mary	land
ý.	-	Usual Residence of Decedent 10a. State 10b. County			10c.	City, Town	or Locat	ion							10d. Inside (City Limits
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tarylar 28a-f s at on	Director	10e. Street and Number	- Cuc	LICK				10f. Zip (10	g. Citizen	of What Co	ountry?	
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ours af atural camin	d b	15. Decedent's Education (Spe	1.	or Dates:		ed) 16a.	Deceder	it's Usual C	occupation	on (Give ki	nd of work	done	16b. Kind	of Busines	s/Industry	
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21 hould I hould I is mar	٩	19a. Informant's Name/Relation										Route Num			ate, Zip Code)	
, ME and 2 s ealth an em 27		Lori Robinette	- / !	wile		20b. Place					Da				or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crematic		Removal fi	om State	crema Glade	tory or of	her place)			10/10	/2009	Walke	ersvil	le, Mai	yland
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taminer		Immediate Cause (Final diseas or condition resulting in death)	_	/lultiple Inj		nce of):			_						-	
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60, ate be hysici		IF FEMALE:		23c. If yes,	outcome o	f pregnancy	,						23d. I	Date of deliv	/ery	
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Box e death co	ysic	1 Yes 2 No 9 U	nknown	9 Unkr			2 [] C	ther (Spec					7			
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1 Of \ ling Phy After th funeral	n: To	27. Manner of Death		28a. Date	e of Injury h. Day, Year) 2009	1	. Time of	Injury :	_	ry at Work	l Dri	d. Describe				
ivision I or Attendi after death. Director:	atio		nding estigatio	on L			18 hrs		L.m.	Yes 2 🗸	No				· Rural Route N	umbor City
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a site of the funeral director.	Certification:	de	uld not b	e		- At home, Road / H			, oπice t	ouliaing, eta	910	or Town, 34 Stauffe	State) r Road, V	Valkerville	, Md.	umber, City
Hospi 24 hou Funer cely fil		4 Homicide 29a. Certifier 1 Certifying	Physicia	n: To the be	st of my kn	owledge, d	eath occ	urred at the	time, da	ate and pla	ce, and du	e to the cau	se(s) and	manner as	stated.	
To the Hos within 24 h	Medical	one) 2 Medical Ex		On the basis	of examina stated.	ation and/or	investig				curred at th	e time, date				
	ž	29b. Signature and title of certi	fier	, 1,				29	. Licens	se number				ate signed oer 3, 20	(Month, Day, Ye 09	ar)
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10+1		30. Name and address of personal Margarita Korell MD.		sistant Me				Penn Str	eet, B	altimore	, MD 21	201				
	tate	502 M T 1	772		Registrar's S		1 1	barke	1							_
Regis	trar	UCIL	1 4 4	009	CEYLEGA	~ p	7							0	CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34646 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2009 MARTIN JOSEPH ROCHE 11:43A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **⊠**M 2 □ F Months Hours Min. Dec. 24 1936 Connecticut Director 044-28-5311 72 Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Md. Montgomery Laytonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22411 Rolling Hill Lane 20882 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meagnes. Elementary/Seconday (0-12) College (1-4 or 5+) Mathematical Aerospace Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Patrick Roche Mary Bridget Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Antoinette Roche Wife 22411 Rolling Hill Lane, Laytonsville, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 10/14/09 Germantown, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Ho P O Box 5038, Laytonsville, Home -00470 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or as a con) quence of): Medical resulting in death) Examiner with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or s a conseque co Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE use es, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed After this certificate has Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 🗌 Yes 2 110 မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: injury s after dear ral Director: After by the fire 1 Natural 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗍 only one)

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 A

32. Registrar's Signature

29c. License number

004

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 6:11 p^M 10 John Robert Rohloff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day) Days Hours 1 X M 2 □ F 342-36-4735 01/31/1944 North Carolina 65 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Ocean City MD Worcester 10g. Citizen of What Country? 10e. Street and Number 21842-5320 U.S. of A. 52nd Street 210 W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zheta Julia David John Frederick Rohloff ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Rohloff Wife 210 W. 52nd Street Ocean City, MD 21842-5320 20b. Place of Disposition (Name of cemetery, crematory or other production Crematory or other production) 20a. Method of Disposition 20c. Location - City or Town, State
Alexandria 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2009 Virginia 21. Signature of Funeral Service 22 Mame and Address of Facility Loudoun Funeral Chapels 158 Catoctin Cr. SE Leesburg, VA 20175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Pulmonory disease or condition resulting in death) Chrimte Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 😾 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, P.O. Records, Division of Vital

attending physician and for use as the burial-tran signed by the a has After 1

Funeral

Director

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1
Department of H
Important: If ite
any injury or ot
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Physician

Examiner

/Medical

 ρ_{OO} 10/07/2009 ρ_{OO} Baltimore, Maryland 21215-0036

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John R. Roblo 64

ne Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After ti filled in by the

Physician/Medical ģ Completed Be Certification: To 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier MID 29c. License number D0064120 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aut 9733 Health Waynnive Boxlin. MD 21811 TIF ZEESHAN

31. Date filed (Month, Day,

32. Regis ar's Signature Roserva

within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Oct.5,2009 9:25a Physician Ruhling Faye /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Park Montgomery **Examiner** Takoma Apt.3 8209 Greenwood Ave. 9. Birthpiace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 8 Month Day (942 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Tennessee Months Days Hours **Funeral** 1 □ M 2 🗓 F 422-52-4168 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location I and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 28a-f ahow if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Takoma Park Montgomery MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20912 USA 8209 Greenwood Ave. Apt.3 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status White 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Baltimore, Maryland 21215-0036 \$ 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Hudson Leonard Dwight Methvin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda 20912 19a. informant's Name/Relationship (Type. Print) 8209 Greenwood Ave Apt.3 Takoma Park, Md Richard Ruhling/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or c ţ 1 X Burial 2 ☐ Cremation 3X Removal from State Lawrenceburg, TN. 10/7/2009 Greenwood Cem. 5 Other (Specify) 4 Donation PHILIPADS RIWALDI FUNERAL SERVICE, P.A. Funeral Service Lice is e 23a. P. rt1. Enter th. A isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Physician /Medical Due to (or as a consequence of): Cerebro vascular accident **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Immune thrombocytopenic purpura or Attending Physician; The law requires that the death certificate be executed physician and the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Year 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy page 2 2 No 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2XNo Certification: To After this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Hospital 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D68686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Center Dr. #200 Silver Spring, MD Frederick David Min M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) park 15

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)) Crobel Physician/ Kenneth Lee Richardson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth
Jan, 10,1938 5. Social Security Number 6. Sex 1 X M 2 □ F **Funeral** Hours MarvIand Jan, Director 214-34-7689 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director West 1 Tes 2 No Berkeley County Martinsburg Virginia B 10f. Zip Cod€ 10g. Citizen of What Country? Funeral 25404 U.S.A. 100 Eclipse Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give 1956-1964

Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: White 3 Widowed 4 XDivorced Completed other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Setup Operator Truck Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic even ည William Clark Richardson Virginia Mae Bonar Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trainonce. 9123 Stottlemyer Rd. Boonsboro, MD 21713 Lori Ann Porikos-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar LAwn Mem. Park 10-20-2009 Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner WUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine ue to (or as a consequence of) renmone Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last wis Ropio Vanticalar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. as case referred to mulical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 350 MILL ST. HAGERSTOWN MD 21700 ANDRADE EXAMEISCO

3+1 4+1 State

Registrar UC1 & 9 2

2. negistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Joseph Rooney 06:30 M 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO MP01121 410NM If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 579-14-3615 Director 88 Maryland 04/18/1921 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Important Examment to other traumatic event, Director 1X Yes 2 No Wicomico Maryland Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Race St. 21869 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: 3X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lathe operator metal 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chauncey Rooney Mary Yetter ပ 19a. Informant's Name/Relationship (Type. Print)
Elizabeth DiGennaro/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Race St., Vienna, MD 21869 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/12/09 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Furieral Service License 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVO **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Useass or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 1 ☐Yes LENo Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes \2 | 1 | No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OGESH

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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EASTERN

32. Régistrar's Signature

29c. License number

SHORE

63199

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SAUSBURY

29d. Date signed (Month, Day, Year) 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15:35 Silberman October 0 Car1 <u>Robert</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick <u>9510 Pocono Court</u> Frederick 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 XM 2 □ F (Month, Day, Year) Hours Min New York Director 092-34-2156 66 May or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 9510 Pocono Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) New York Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Public School System Guidance Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Silberman Anne Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9510 Pocono Court, Frederick, Maryland 21702 Stacy Ukishima / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important; If it 1 Burial 2 X Cremation 3 Removal from State October 4 Donation 5 Other (Specify) 2009 Smithsburg Crematory <u>Smithsburg, Maryland</u> 22. Name and Address of Facility
Keeney and Basford PA Funeral Home,
106 E. Church Street, Frederick, Maryland 21701 Signature of Funeral Service Licenses MO1473 23a. Part 1. Enter the discase, or complications that caused shock, or heart failure. List only one cause on each line. rise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for se's consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusinan and attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 2 🗌 No 20 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State

Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature and title

30. Name and address of

nama

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sweitzer Eugene Elden 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Co. Nursing & Rehab Ctr. Cumberland Allegany Date of Birth (Month, Day, Ye Nov 29, Birthplace (State or Foreign Country) WV 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex), 1943 1 → M 2 □ F Months Days Hours Min. 213-40-3439 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count MD Allegany Cumberland 1 □ Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 110 Park Street Apt. 1 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-Owner/Project Director General Graphics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harvey Emerson Sweitzer Clara Alberta (Simms) Sweitzer 19a. Informant's Name/Relationship (Type. Print) Elden Sweitzer, II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Holland Street Cumberland MD MD 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Øemation 3 ☐ Removal from State 10/23/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Offner (Specify) 21. Signature of Funer Service Lice 22. Name and Address of Facility and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death ARCIDOMA Due to (or as a consequence of): Dualto (or sele consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Department of Health Important: If item 27 any injury or other trong once.

Physician

/Medical

Examiner

10a. State

Funeral Director

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Completed

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Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Expriner must be notted at

Baltimore, Maryland 21215-0036

death with the Maryland

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria signed by the a certificate has been s rector, page 2 should funeral director. After this 324 hours after death.

e Funeral Director: Af within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760, $\zeta_{
m I}$

Immediate Cau - (Final disease or condition resulting in d - (II) Sequentially list conditions, if any, leading to influent accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 Mo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Nun 5

State Registrar 30. Name and address of person who comp

ROBUSTIMO

31. Date filed (Month, Day, Year)

1 ST. CUMBERLAND

eted cause of death (Item 289) (Type, Print)

32. Registrar's

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GL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34653 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 10, 2009 JAMES ROBERT SMOOT 11:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGES FORT WASHINGTON MEDICAL CENTER FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Y. AUGUST 26, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 1 M 2 □ F Hours MARYLAND 59 214-58-1775 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 **405 PATUXENT COURT** UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian Black, White, etc 1 ⊟Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 XNo Specify: δ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WASHINGTON SUBURBAN d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Flementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) SANITARY COMMISSION FOREMAN OF OPERATIONS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be

JOSEPH SMOOT 19a. Informant's Name/Relationship (Type. Print)

20a. Method of Disposition

HAZEL WRIGHT SMOOT

QUEENA SMOOT / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35775 ARMY-NAVY DRIVE, MECHANICSVILLE, MARYLAND 20659

Date

1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) SACRED HEART CHURCH CEM.

OCTOBER 17, 2009 LA PLATA, MARYLAND

20c. Location - City or Town, State

ATULA C. THORNION JOHNSON MOOS83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

40 card 10 Due to (fr as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of)

Approximate Interval Between Onset and Death

resulting in death) Last

23d. Date of delivery Month Day

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

23e. Did tobacco use contribute to the cause of death?

2 No

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	1 ☐ Yes	2] No	3 🗌	Probably	Unknown
a.	Was an autopsy performed	2/	24b.	Were prior t		indings available tion of cause of

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 ☐Yes

27. Manner of Death Natural 2 Accident 3 Suicide

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

and manner stated

1 ☐ Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2. No

4 Homicide 29a. Certifier (Check only one)

Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

DOUS6 Or

29d. Date signed (Month, Day, Year)

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20744

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evonce.

Physician

/Medical

Examiner

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certificate

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nours after death neral Director: / filled in by the f death.

within 24 hours a To the Funerai [

The law requires that the death certificate be executed

Box 68760,

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Division of Vital Records,

Hospital or Attending Physician:

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Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

ARVIND NARASIMHAN, M.D. FORT WASHINGTON MEDICAL CENTER 11711 LIVINGSTON ROAD, FORT WASHINGTON, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Patricia A. Smith Y to be 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARLES CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖫 F Director 577-52-4608 May 13, 1935 Washington DC Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7340 Gabriel Drive 20616 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 ∏No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify. ¥☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, I'm ones. Homemaker Her Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry F. Welsh ပ Grace C. Kiplinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin I. Smith, Jr. Son 28 Jonquil Place, Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2009 Indian Head, Maryland St. Charles Cemetery 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service Lig M00668 4270 Hawthorne Rd., Indian Head, Md 23a. Part 1. Enter the shock, or hear! isease, or complications that a sailure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Final Immediate C 0 **Physician** disease or condition resulting in death) /Medical s a consequen e of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit 7475121 that initiated events resulting in death) Last to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 🗌 Yes No No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/2/00 1 ☐ Yes 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier completely (Check only

BX State Registrar

31. Date filed (Month, Day, Year) OCT

29b. Signature and title of certifier

one)

SCORGE

11345 Pem brooke Square Seite 103 (Valdo MD 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

WATHEN

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 tem 25 amended G897 G897 11/6/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 9:25 AM September 27,2009 Lillian D. Shelton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ade 1phi
ader 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Prince George's Hillhaven Nursing Home Birthplace (State or Foreign Country)
 DC 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F Feb. 07, Director 577**-**52**-**5260 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ar than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20017 4961 12th Street, North East filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNO Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black _ |} If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, tra INS ponce. Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental Ida Scott ဥ Abbington Joy Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4961 12th Street, NorthEast, Washington, DC 20017 Joseph Shelton/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery | Oct.2,2009 | Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Six Jure of Funeral Service L 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NorthWest, WashingtonDC20012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SMINS á disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DRONAMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit neumonna and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed/ 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: Tis after death. director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 □ Yes 2 □ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 2009 017843

State

Registrar

M.D 3311 Taledo Terraco + B102 Hyabsville Md. 20782

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

CVAID

31. Date filed (Month, Day, Year)

OCT

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct. 10, 2009 Shelton Delores 0250 Μ. 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/06/1935 Birthplace (State or Foreign Country) Alabama 5. Social Security Number 1 □ M 2**X** F Months Days Hours 418-54-8152 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring MD Montgomery 1 ☐ Yes 2 XNo 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 20910 9101 Second Avenue USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2√☐ No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Schools Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Averette Foster Manley Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Shelton Jr./Son 5921 Founders Crossing Court#201 Alexandria, e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 10/13/2009 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specific 21. Signatur § HILIT ANGRESTINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Due to (or as a consequence of): Urosepsis Sequentially list conditions, if any, leading to immediate cause. Erner Univerying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Metabolic Acidosis Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown 24a. Was an

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

Pages 1

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

Director

Funeral

<u>a</u>

Completed

Be

2

Examiner

Physician/Medical

Completed

Be

Certification: To

filled in by

within 24 hours a

To the Funeral D

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-tran attending physician the for the signed by

Division of Vital Records, P.O. Box 68760,

in the past 12 months?
1 ☐ Yes 2 ANo 9 Unknown

metastatic uterine cancer, liver metastases, ascites

autopsy performed? Yes 2 No 1 ☐ Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 DANO

1 Yes 2 No 27. Manner of Death 1 A Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

25. Was case referred to medical examiner?

Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year)

26. Place of Death (Check only one)

Suparuch PSM MD

D0065485

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15

Barbara Supanich 1500 Forest Glen Road Silver Spring, Md 20910 M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signa

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 6:15 A. M **Physician** October 4, 2009 Welling B. Souder /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Poolesville 6 Selby Court If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, July 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year Days 11€ M 2 □ F 1925 Washington, D.C. Yrs. 84 Director 577-20-7660 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f shot any injury or other traumatic event, the Marked Eventing must be mailtied at once. 1 XYes 2 ☐ No Directo Poolesville Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 20837 6 Selby Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 28 Married 2 No white Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: 9 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Manager Installation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa Follen Oscar Souder, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Catherine Souder - wife 6 Selby Court, Poolesville, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-8-2009 Frederick, Maryland Resthaven Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home Signal re of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21704 lue 23a. Part 1. Enter the disease, or complications that caused the d.a.h. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) / /Medical Due to (or as a conseque re of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitiated events resulting in death) Last a conse vance of): Physician/Medical Examiner To the Hospital or AttendIng Physician; The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manper of Death After 1 Natural 5 Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Let Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

3

DHMH 17 Rev 1/2001

License number

29d. Date, signed (Month, Day, Year)

October 5 209

and manner stated.

32. Registra

2009

who completed cause of death (Item 23a) (Type, Print)

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	f Marylan		artment of I		and Mental H	ygien Reg. N	000	9 34658
Ī	Physicia	n/	1. Decedent's Name (First, Middle, RUDOLPH REUBEN						2. Date of I		7, 200	3. Time of Death 13:11 P M
1	Medic Examin		4a. Facility Name (if not institution, SOUTHERN MARYLA	give street and num. ND HOSPIT	ber)	ER	4b. City, Town, o		f Death	P P	c. County of D	eath GEORGES
~	Funeral Director	.5			7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8, Date of E Min. NOVEYB			Birthplace (State or Foreign Country) FLIZE
	aryland a-f show fied at		Usual Residence of Decedent 10a. State 10b. County MARYLAND CHARL	.ES	100	, Town or Lo	cation					10d. Inside City Limits 1X Yes 2 □ No
	with the Ma 23a or 28 ust be noti	Funeral Dire	10e. Street and Number 3808 BREWSTER C				10f. Zip Code 2060)1			itizen of What	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fun	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	A resond East	e		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🗶 No		gin? (Specify Yes or N , Puerto Rican, etc.)	0-	Black, W	omerican Indian, White, etc. ONDURIAN
Baltimore, Maryland 21215-0036	ithin 72 hour ene. r than "natu the Medical	Completed by	15. Deceden (Specify only higher Elementary/Seconday (0-12)	t's Education st grade completed) College (1- 2 YEARS	-4 or 5+)	(Give life, D	dent's Usual Occup kind of work done O NOT use retired LIFT OPI	during most)		RE		ess Industry ING & RESTORATIO UIPMENT
land 2	be filed w lental Hygi rked othe lic event, i	o h	17. Father's Name (First, Middle, L. LEOPOLD RUDOLPH					1	er's Name (First, Mido N NARED	le, Maide	n Surname)	
Mary	d 2 should alth and N 27 is ma ir traumai		19a. Informant's Name/Relationsh AUDREY TUCKER /						TE, WALDO			
more,	Page 1 and nent of Her int; If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from	01-1-	emetery, crei	psition (Name of matory or other place) FOHOLS CRE	ATORY	OCT. 16,2009			y or Town, State
Balti	permit. Departn Importa any inju		21 atture of Fusical Security		M00583	Ti 3	Name and Addr HORNION FUN 439 LIVING	ess of Facilit VERAL HO STON RO	ÖME, P.A. AD. INDIAN H	EAD. 1	MARYLAND	20640
1	Priysician/	100	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that only one cause on ea	ich line.	h. Do not ent		ng, such as	cardiac or respiratory			Approximate Interval Between Onset and Death
	Medical Examiner	<u>ا</u>	resulting in death) Sequentially list conditions,	b	(or as a consequence of the cons	ED (OPATHY			
	e be executed ysician and e burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	6 <u> </u>	(or as a consequence of the cons	JARY	ARTE	RY	DISEASE			
09/	cate be e physicial s the buri	edical	1	L d								
Box 6876	e death certificate b the attending physi hed for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 🔲 Live	tcome of pregna Birth 2 D Feta gnant at time of nown	aldeath 3	Ectopic pregnal Other (specify)	ncy		_	23d. Date o Month	of delivery Day Year
s, P.O.	requires that the dea been signed by the a should be detached f		Part II. Other significant condition	ons contributing to c	leath but not res	sulting in the	underlying cause (given in Part				te to the cause of death?
of Vital Records,	has le 2 s	Completed by							p	as an utopsy erformed	prio dea	e autopsy findings available r to completion of cause of th? I Yes 2 \(\square\) No
a		Bec	25. Was case referred to medical examiner?	Haaritali					ath (Check only one)			
Z	hys his al dii	ုင	1 ☐ Yes 2 ☑ No		Inpatient 2	1	ent 3 LI DOA		ursing Home 5 R			Specify)
on of	Attending Physic death. ector: After this by the funeral di	Certificate:	27. Manns of Death 1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation	oth, Day, Year)	28b. Time of injury	M 1 [rk? Yes 2] No		jury occurred	
Division	spital or Attending Pours after death. Peral Director: After tilled in by the funers	cal Certi	4 ☐ Homicide determ	nined 28e. Place build	ing, etc. (Specif	y) 	reet, factory, office		City or	Town, Sta	ite)	or Rural Route Number,
	id of iii	Ö	29a. Certifier 1 Certifying	Physician: To the I	est of my know	rledge, death	occured at the tin	ne, date and	place, and due to the	cause(s)	and manner a	as stated.

Descripting Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune (Check only one) 29b. Signature and title of certific 29c, License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD ASHRAF, 5711 SARVU AVENUE MUHAMMAD 32. Registrar's Signature 31. Date filed (Month, Day.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22, 2009 **Physician** Ronald Keith Wiley October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** A 1 1e 991 raddock UMbes/gna nder 1 Year I I Under 24 Birthplace (State or Foreign Country) Date of Birth (Month, Day, 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours X M 2 D F 74 Director 234**-**56-5103 8/26/35 Keyser, WV Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland thit and Mental hyglene. Professer is marked other than "natural", or items 23a or 28a-f show traumatic event, he, hedical Exprinter must be nealthed at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1XYes 2 No WV Mineral Keyser Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 94 Maryland Street 26726 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White ₽ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pulp & Paper <u>Paper maker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce Otto Wiley Pansy Marie Barnhouse ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur once. 1450 Lynmar Street, Keyser, WV 26726 Rhonda Swayne 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/09 | Keyser, WV Potomac Memorial 4 □ Donation 5 □ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown VO SI Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the contr 29a. Certifier Medical (Check only one) Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

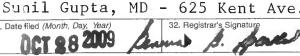
To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

5 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title Si-co



625 Kent Ave.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

10033280

Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

2000

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		For State Registrar	State	OI WI	ai yiai k		•	ficate of			nemai ii	Reg. N	200	19	346	560
Physicia /Medic		Decedent's Name (First, Middenson Name (2. Date of D Month Octobe	r 9,	ay Yea 2009	r 6	Time of De	eath A ^M
Examine Funeral Director	er	4a. Facility Name (If not institution 6917 Skyline P 5. Social Security Number 217–78–1007		7. Ag	e (In yrs. I: 41	a <i>st birthi</i> Yr	day) If	Bryans Under 1 Year onths Days	Road	d der 24 Hrs.	8. Date of E (Month, i	Birth Day, Yea	r) (3	(State or F	Foreign
show	ō	Usual Residence of Decedent 10a. State 10b. County			10c. City										Inside City	
with the M 3a or 28a-f	Direc	Maryland Char 10e. Street and Number 6917 Skyline P			вту	ans	Road	a 10f. Zip Code 206					Citizen of What	Country?		
40 B	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Do Armed 1 ∐Ye If Yes,	Forces?		5.		S Decedent of es, specify Cu	Hispanio ban, Mex		ecify Yes or f Rican, etc.)		J.S.A. 14. Race - Ar Black, Wh Specify: V			
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important; If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnes.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		ed) e (1-4or 5	5+)	(Give kind life. DO	t's Usual Occi d of work done NOT use retir nter	e durina i	most of work	ing	16b.	Kind of Busines Hotel	ss/Industr	ry	
ould be filed Mental Hyg arked othe attic event,	To Be C	17. Father's Name (First, Middle, Richard Alfred	Wood, J	c						Ida Ma	e (First, Midd e Pull	iam				
1 and 2 sho Health and Sm 27 is m Ther traum		19a. Informant's Name/Relations Shelli A. Wood 20a. Method of Disposition	ship (Type. Print)	Wi		691	7 S	*		ce, Br		oad,	Md. 20 Location - City	616		
it. Pages rtment of rtant; if ite njury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	m State	C	emetery,	cremato Me	m. Gar	dens	10/1	3/09		Waldorf,			
permi Depar Impo any ir		21. Signature of Funeral Service 23a. Part1. Enter the direase, of	lla	- 7	M0066		W1.	ame and Add lliams 70 Haw he mode of do	Fune hort	erai H ne Roa	d, Ind	ian	Head, M	Ap	proximate	
bur jcis	edical Examiner	shock, or heal Filure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due b Due	to (or as	a consequa consequa	ience of):	ART	ER'	Y I	DISEA	SE			erval Betwe	
Attending Physician: The law requires that the death certificate refers. After this certificate has been signed by the attending physe by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 □ Pi	ve birth	of pregna 2 ☐ Fetal at time of d	death		ctopic pregna ther <i>(specify)</i>				-	23d. Date of Month	delivery Day	y Ye	ar
w requires that the base of the signed by should be detac	þ	Part II. Other significant condit	ions contributing to					rlying cause g	jiven in P	art I.			o use contribute			
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Physicial this certi al directo	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hoopitals	☐ Inpati	ent 2 🗌	ER/Outp	oatient	3 □ DOA O	thor		th <i>(Check on)</i> ome 5 ∑ Re		6 ☐ Other (S	Specify)		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could	ng (A tigation	ate of Inju	ury - At ho	me, farn	ury	M 28c. In W	□Yes	2 No	28f. Location	(Street	and Number or	Rural Ro	oute Numbe	er,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Cert	29a Certifier 1 X Certify	ing Physician: To	the hest	of my kno	wledne	death o	ccurred at the	time, da y opinion	te and place	and due to t	he cause ne, date a	e(s) and manne	r as state	ed. e cause(s)	
To the within 2 To the Comple	Mec	29b. Signature and title of certification.	er		ateu.		-	29c. Lice	nse numl	ber 578	200	29d.	Date signed (M	onth, Day	(Year)	
DB3		30. Name and address of person MUI+AM 31. Date filed (Month, Day, Year	MAD +	ause of o	death (Item	1 23a) (T	Type, Prin	11 Sa	wî.	ave	nul #1	00,	Rivelda	4, n	102	073
Sta Registr		001 1	4 2009	dens	wa	ß.	pa	ake								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elizabeth Marie West October 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 K 81 209-20-9885 Yrs **Director** 11-6-1927 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f shorthe Medical Examiner aust be notified at 1 □Yes 2 No Directo MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1077 Largo Road 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 🔼 No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. White 3 XWidowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Title Examiner</u> MVA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H Be ၉ Thomas Bynon Thomas Sarah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Pages 1 and 2 sh tment of Health and tant: If item 27 is m permit, Pages 1 and. Department of Health Important: If item 27 any Injury or other troonce. William T. West/Son 6380 Boundary Run Dr., Mechanicsville, VA 23111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 10/15/2009 Cheltenham, Maryland 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner umon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical ied by the attending phys detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year ☐Yes 2 No 5 Other (specify) 9 Unknown g D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 29a. Certifier 🗺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the I 29b. Signat 29d. Date signed (Month, Day, Year) 29c. License number

State

EUZAB

DHMH 17 Rev 1/2001

Registrar

Nade

31. Date filed (Month, Day,

da

Good

Road

8118

ss of person who completed cause of death (Item 23a) (Type, Print) Lovalchuk

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Ø8t 10, 2009 12:15 P M May Sheila Walls Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days April 1 1 1 M 2 □ F Months Min. 49 214 78 6051 Maryland Director ′1960 Usual Residence of Decedent or 28a-f shov 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Prince George's Cheverly 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9817 Dorval Ave items 23a Funeral 20772 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . Or P Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Black 1 Yes 2 XXNo Specify: "natural", 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Newman Elizabeth Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 9817 Dorval Ave, Upper Marlboro, MD 20772 Clarence M. Walls (Husband) 20a. Method of Disposition

1 Description
Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cemetery 10/17/2009 Clinton, Maryland Resurrection 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Road, Clinton, MD 20735 Alexandria Ferry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a onsequence of). Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Phelimama Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 XXNo ŏ Month Year Day Pregnant at time of death been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' death? certificate Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Tes 2 **□X**No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? s after death. 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State

31. Date filed (Month, Day, Year) 1 3 2009 OCT

29b. Signature and title of certifier

30. Name and address of person who comple Sarzad Malekanian,

32. Registrar's Signature

Registrar

mpleted cause of death (Item 23a) (Type, Print) n, M.D. 7501 Surratts Road, Clinton, MD

D0065729

29d. Date signed (Month, Day, Year)

10/12/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici /Medic Examin	a
Funeral Director	

Williams, Cerrine

			1 - For State Registrar	State of M	ai yiai iu /	•	icate of		a wientai i i		200	9 31,663
	Physic	ian	1. Decedent's Name (First, Middle, CORRINE M. W			-			2. Date of D Month	Day	Yea	5. Hille of Beath
-	/Medi Exami		4a. Facility Name (If not institution,		1	4b	City, Town, or	r Location of De	eath 10		County of De	eath
	Funeral Director		5. Social Security Number 180–32–9469	5. Sex 7. A	ge (In yrs. last t		Under 1 Year onths Days	If Under 24 H Hours M		735	9. E	Birthplace (State or Foreign Country)
	yland how at		Usual Residence of Decedent 10a. State 10b. County			wn or Locatio						10d. Inside City Limits
	ne Mar 18a-f s	ector	VA Accor	nack	Atla		VA 233	0 3		1		1 ☐ Yes 2 📉 No
	h with the 23a or 2	al Din	10e. Street and Number 8255 Atlantic	≀d.		1	0f. Zip Code 2330	3		10g. Citi	zen of What (Country?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event.	d by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' d 1 \[Yes 2 \] If Yes, Give Year or Dates:	?		Decedent of H s, specify Cuba /es 2 🛣 No	lispanic Origin? an, Mexican, Pu <i>Sp</i> ec <i>ify:</i>	(Specify Yes or Nerto Rican, etc.)		14. Race - Ar Black, Wh Specify:	
15-(n 72 h "natu ledicel	Completed	15. Decedent's (Specify only highest	grade completed)		a. Decedent' (Give kind life. DO N	s Usual Occup of work done of	ation during most of vid)	vorking	16b. Kii	nd of Busines	ss/Industry
212	d withi giene. er thar	Som	Elementary/Secondary (0-12)	College (1-4or	5+)	Superv				Fo	od	_
and	be file ntal Hy ed oth event	Be	17. Father's Name (First, Middle, L. Jefferson Milb	•					lame (First, Midd. e Downin		Surname)	
Maryland	should nd Me marke	은	19a. Informant's Name/Relationshi		19	9b. Mailing Ad	idress (Street		Rural Route Num		Town, State	, Zip Code)
	and 2 ;		Gloria Hinman,	,					pt. B-2			
Baltimore,	ges 1 at of He iffiten		20a. Method of Disposition 1★ Burial 2 ☐ Cremation 3	Removal from State	I		n (Name of ry or other place		Date		-	or Town, State
Itim	nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (8pt) 21. Signature of Funeral Stylice (1)		St. J		M. Cem		0/17/09	At1	antic,	, VA
Ba	any per		amen 10.	OODE K				•	Funeral	Co.,	Ассова	ac, VA
			2°a. Part 1. Ent r t e = ease, or c shock, or eart failure. List o	om cations hat cause not ne cause on each I	d the death. De	o not enter th	e mode of dyir	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
d	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. UTRI	-		4RC1	NOM	+			Onset and Beam
7	Examiner				a consequence	e ot):						į.
	ed sit	iner	Sequentially list conditions, if any leading to intradiate cause. Enter Underlying Cause (Disease or injury	b. — Suinto (or as	a consequence	e of):						
	rificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):						
68760,	ate be nysicia he buri	Medical		d								
	sertifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome	of prognancy							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pegnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 ☐ Fetal dea at time of death		opic pregnanc er <i>(specify)</i>	у			23d. Date of o	delivery Day Year
	w requires than been signed should be det	፩	Part II. Other significant condition	s contributing to death t	out not resulting	in the underl	ying cause give	en in Part I.		/	0	to the cause of death? Probably 4 Unknown
Vital Records,	n: The law r ficate has be r. page 2 sh	Completed			· · · · · · · · · · · · · · · · · · ·				per 1 □ Yes	opsy formed? 7 No	24b. Were prior t death 1 □ Ye	
ΙŽ	Physician: r this certific ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/0	Outpatient 3	□ DOA Oth	or.	eath <i>(Check only</i> Home 5□ Re		Other (S)	pecify) Hospics
n of	ding Ph h. After th funeral	on:T	27. Manner of Death 1	28a. Date of Inj (Month, Da	ury 28b	. Time of Injury	28c. Injur Worl	y at k?	28d. Describe			
Division	or Atten after deat Director: in by the	Certification:	Accident Investiga	t be 28e. Place of In	jury - At home, lc. <i>(Specify)</i>		-	Yes 2 □No	28f. Location City or T	(Street and own, State)	d Number or	Rural Route Number,
	Hospital 24 hours a Funeral I		(Check only 2 Medical E	Physician: To the best caminer: On the basis	of examination							
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner s			29c. Licens					onth, Day, Year)
	F3Fö		1						(0			
9	~10		30. Name and address of person w	no completed cause of	2 .4	(Type, Print			(0)	-	112/	2 4 2 2
P	71 Z Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	F 17	735	SACY	13642	p u	0	L100 L
	Pogiat		nrt 1	5 2009		6 6	a. U. J		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Warren Basil Ward October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Point PERRY VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months nown to physician! WARD, 193-18-2971 Director 84 May 1, 1925 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Ceci1 Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 775 Ragan Rd. 21918 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1963-65 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ş 3 ☐ Widowed 4 💆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Merchant Mariner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental | ပ Harry S. Ward Ruby Smith and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau once. David L. Ward/Son 193 Lone Pine Dr., Palm Beach Gardens, FL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10-16-2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State A M 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 sch are 23a. Partil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one / juse on each line. Immedi ne Cause (Final disease or condition resulting in death) Carcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be exec Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed page 2 should has

23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

HO054439

34664

544AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

33410

Approximate Interval Between Onset and Death

2 years

Year

1 ☐ Yes 2 X No

Pennsylvania

Year

13, 2009

4c. County of Death

Cecil

USA

16b. Kind of Business/Industry

Merchant Marine

23d. Date of delivery

29d. Date signed (Month, Day, Year) October 13, 2009

Day

14 Bace - American Indian

White

State

certificate

Aftert

filled in by the

ne Hospital or Attending P n 24 hours after death. e Funeral Director: After t

Be

P

Certification:

Medical

Division of Vital

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

Vincent A. giminaro, Du VA maryland Hearth Care System, Perry Point, m) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

person B. parked

Registrar

Exam

	For State Registrar 1. Decedent's Name (First, Middle, Last)	C	ertificate of D	eath	Reg.	No. 200	9 3466 3. Time of Death
cian lical iner	ROBERT E WIL 4a. Facility Name (If not institution, give street and nur		4b. City, Town, or L		Month	Day Year 4 2009 4c. County of Dea	5:43 P
	FREDERICK MEMORIAL HOSPI 5. Social Security Number 6. Sex 10X M 2 F	TAL 7. Age (In yrs. last birthd. 71 Yrs	Months Days		8. Date of Birth 3 / 6 / 1 9 3	FREDERIC 9. Bir	CK rthplace (State or Forei cuntry)
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			3707133		10d. Inside City Limi
Director	MD Frederick 10e. Street and Number	M	iddletown		10g.	Citizen of What Co	1 ☐ Yes 2 📉 Nountry?
eral D	7300 Aspen Ct.	T.	217			USA	
by Funeral	11. Marital Status 1 □ Never Married 2 💆 Married 3 □ Widowed 4 □ Divorced 12. Was Dece 1 □ Yes 1 □ Yes 1 □ Yes 1 ∀es or or or	2 7 No /e	3. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☐ No	panic Origin? (Spe , Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	te, etc.
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(G	ecedent's Usual Occupative kind of work done du character (Cartired) adminis	ıring most of workir	109	o. Kind of Business federal	•
To Be Cc	17. Father's Name (First, Middle, Last) Clyde Wilson		7	18. Mother's Name	(First, Middle, Maid Grove	den Surname)	
	19a. Informant's Name/Relationship (Type. Print) Rosella Wilson (Wife		ailing Address <i>(Street ar</i> 00 Aspen				
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	20b. Place of Discemetery, Carlotter	sposition (Name of crematory or other place, an cemete	ry 10/8		iddleto	
	21. Signifure of Funeral Service Ligersee		Donald B POB 18,	of Facility omp	son Fund	eral Ho	me
		aused the death. Do not ach line. one Adaptor or as a Insequence of	Discose	, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
cal Examiner	cause. Enter Underlying that initiated events c.	or as a consequence of): or as a consequence of):					
Physician/Medical	in the past 12 months?	ant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
by	Part II. Other significant conditions contributing to de	eath but not resulting in the	e underlying cause giver	n in Part I.	23e. Did tobac	-	o the cause of death? Probably 4 Unknow
Completed	Congestai Heat Failure	Black	ler Conce		24a. Was an autopsy performed	prior to death?	utopsy findings availal completion of cause of
Be	25. Was case referred to medical examiner? Hospital:		4 045	26. Place of Death			
tion: To	27. Manner of Death 1		e of 28c. Injury Work?	at 2	ne 5 Residence		ecify)
Certification:	2 D A Seite Could not be	of Injury - At home, farm, ng, etc. <i>(Specify)</i>			8f. Location (Stree City or Town, S	t and Number or F State)	Rural Route Number,
Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the brand mann and mann	asis of examination and/o	eath occurred at the time r investigation, in my opi	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner a and place, and du	as stated. le to the cause(s)
M	29b. Signature and title of certifier		29c. License			Date signed (Mon	
	30. Name and address of person who completed caus Kevih E. Hohl mi) Bos 20,	3005. ehvel	st. Mille	Lesown M	1 21769		
ate	31. Date filed (Month, Day, Year) 32. R. OCT 13 2009	egistrar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

09-08094 W

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liam R. Whit	ten		ate of Maryla	nd / Depa		Health ar		l Hygiene				
		1- For State Registrar		Cert	tificate of	Death			Reg. No.	26	3. Fifme of Death 6 6	
Physici edical Exami		1. Decedent's Name (First, Middle William	e,Last) Raymond W	hitten				2. Date of Month Octobe	Death Day er 18, 200	Year	1130 hrs	
		4a. Facility Name (if not institution	n, give street and nur	mber)	4	b. City, Town, a		Death		County of De	ath	
		1518 East Oldtown Ro	ad, Apartment	В		Cumberlar			- 1	llegany		
Funeral Director		ŕ	6. Sex	7. Age (In yrs. Ia	ist birthday) Yrs.	If Under 1 Ye Months Da		Min.		For	Birthplace (State or reign Country) Texas	
		219-98-1527 Usual Residence of Decedent	X M Z F	45	115.	1		Feb.	11,	1964]	riexas	
any		10a. State 10b. County		10c. City,	Town or Location	on					10d. Inside City Limits	
	5	Maryland Alle	gany	Cum	berland						1 X Yes 2 No	
Aaryla 28a-f 1 at o	ect	Maryland Alle 10e. Street and Number	5 3 3 3 3 3 3 3 3 3 3	1_0		10f. Zip Code			10g. Citi:	zen of What C	ountry?	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	1518 East Oldto	wn Road A	pt. B		21	502		Un	United States		
h with	era	11. Marital Status 1 X Never Married 2 Ma	12. Was Deci	edent Ever in U.	S. 13. Was	Decedent of H	ispanic Origin n. Mexican. P	? (Specify Yes o	or No-	14. Race - An White, etc	nerican Indian, Black,	
r deat or ite	Fun		1 Yes	2 X No				,				
s afte rral", niner	ρ	3 Widowed 4 Divo	orced If Yes, Give Year or Dates:			Yes 2 X N		nd of work done		Specify: Kind of Busine	White	
hour "natu	ompleted	Elementary/Secondary (0-12)	College (1			st of working lif			IOD. P	And of busine	ss/industry	
36 hin 72 than sdical	ple	Elementary/occondary (0°12)	2	40131)		None				Non	Α .	
ZT 5-UU36 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Con	17. Father's Name (First, Middle,	- 1		 -	None	18.Mother's					
J Z1Z13-UU36 hould be filed within 72 hou nd Mental Hygiene. is marked other than "nat utic event, the Medical Exa	Be (William J. Whit	ten				D'Arline Dunn					
21 ould by d Men s mar	흔	19a. Informant's Name/Relationsh			19b. Mailing	Address (Stre	(Street and Number or Rural Route Number, City or Town, State, Zip Code)					
and 2 shoul lealth and N tem 27 is n traumatic	0 Y3	William J. Whit	ten/ Fath	er				iddletov	wn, Ma	aryland	21769	
F Heal		20a. Method of Disposition 1 Surial 2 Cremation	3 Demoved for		Place of Disposi crematory or oth		, · ·	Date		Location - City	or Town, State	
Pages 1 cent of 1 int: If i	- 83	4 Donation 5 Other Sp		Jili State	şthaven		al Gar	0/22/200 dens	09 _{F1}	rederic	k, Maryland	
Baltimore, MD 21215-003 permit Pages I and 3 should be filed withit Department of Health and Mental Hygiene Important: I filem 27 is marked other triangry or other traumatic event, the Med	3.5	21. Signatur of Funeral Se lice	Licensee	/				Homes 1				
o 88 5 5 5	0 73	23a. Part I. Enter the disease, or	9000ne	n	1162	1 Oposs	umtown	Pike.	Frede:	rick. M	aryland 21702	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line	aused the death.	Do not enter th	e mode of dying	, such as car	diac or respirator	ry arrest, sho	ock, or heart	Between Onset and	
Medical taminer	i a	Immediate Cause (Final disease	a. Hyper	trophic		vascula	ır dise	ease			Death	
		or condition resulting in death)	Due to (or as a	consequence of	F):							
	i o	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	F):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c.								_,1,0	
d sit	Xal	events resulting in death) Last	Due to (or as a	consequence of	f):		-					
executed an and al - transit	dical F	T IIII THE TEN	d.	23a,27,	nerME.	o897 11	/3/09	<u>тт</u>				
rici pe	edic	X UNPENDED	<u> </u>									
ACCOTOS, P.O. BOX 68/6U The law requires that the death certificate be cate has been signed by the attending physinage 2 should be detached for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	outcome of pregr irth		al death 3	Ectopic	regnancy	23	 d. Date of deli Month 	very Day Year	
h cert	icia	past 12 months?	4 Pregn	ant at time of de	ath	ner (Specify)			1		,	
e deat the at	Phys	1 Yes 2 No 9 Unk	g Unkno	own								
ires that the signed by I be detach	by P	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	nderlying cause	given in Part				e to the cause of death?	
ires th	o p	<u> </u>						_			Probably 4 Unknown	
ords, v requir s been s should	Completed								Was an autopsy		e autopsy findings available to completion of cause of	
he law ate has age 2 sl	E E	4							performed? Yes 2 N	deat	h? Yes 2 No	
		25. Was case referred to medical				26.Pla	ce of Death (C	Check only one)				
Of VITAI RECOIGS, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	o Be	examiner? 1 ✓ Yes2 No	Hospital: 1	npatient 2	ER/Outpatient	3 DOA	Other:	Nursing Home	5 Reside	ence 6 🗸 C	other: Scene	
I OT ing Ph After 1 funeral	Ë	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Time of Ir	njury 28c. In	ury at Work?	28d. Desc	cribe how inj	jury occurred		
eath.	tio	1 Natural 5 Pend 2 Accident Inves		, 50, , , 00, ,		1	Yes 2	io				
DIVISION tal or Attendir rs after death. al Director: led in by the fu	ifica		d not be	e of Injury - At ho	ome, farm, stree	t, factory, office	building, etc.		tion (Street a	and Number o	r Rural Route Number, City	
pital cours at	Certification:		mined (Specify)					or to	wii, State)			
Hos 24 hc Fun etely	al	(Shook Gill)	nysician: To the bes									
Division of Vital Division of Vital Protection 24 hours after death. To the Faneral Director: After this certific completely filled in by the faneral director,	Medical	2	miner:On the basis of and manner s		nd/or investigat			urred at the time,				
[> [0	ž	29b. Signature and title of certifie	г			1	ise number				(Month, Day, Year)	
		innex (-			0.0	.M.E.		Oc	tober 19, 2	009	
		30. Name and address of person	·								= 5	
0		Ana Rubio MD. Ass	istant Medical E	Examiner	111 Penn S	treet, Baltin	ore, MD 2	1201				
S	tate	31. Date filed (Month, Day Year)	32. Re	gistrar's Signatu	ire /	a Had						

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				artment of Health and Mertificate of Death	lental Hygiene Reg. No. 20	09 34667
	Physic	an	1. Decedent's Name (First, Middle, Last) William Allan Wells		Date of Death Month Day	Year 3. Time of Death
-de	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10 10 d	009 6700 A M
aged.	, Examin		Peninsum Regional Medient Centy	Salisburn		conico
	Funeral		5. Social Security Number	If Under 1 Year	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		09/09/1932	Maryland
	laryland show	_	10a. State 10b. County 10c. City, Town or L	ocation	-	10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland Wicomico Eden			1 ☐ Yes 2 🛱 No
	ath with the Maryls 23a or 28a-f sho		10e. Street and Number 14542 Jackson Road	10f. Zip Code 21822	10g. Citizen of W	hat Country?
	death ms 23	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	USA ecify Yes or No- 14. Race	- American Indian,
98	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar mast ter reditied at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		, White, etc.
Ö	"natural",	ed by	Ye ar or Dates: 190 Y	edent's Usual Occupation		white
215	⊆ . ∈ ∰	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of worki DO NOT use retired)	ng 16b. Kind of Bus	siness/industry
21	d withii /giene. er than	E S		ck driver/superviso	or trucki	ng
nd	be filed ital Hyg id other event,	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
ry S	12 should be filed with th and Mental Hygiene. 7 is marked other that traumatic event, Ine M	၉	James I. Wells	Roxie		
Ma	~ -			ing Address (Street and Number or Rura 542 Jackson Rd., Ed		State, Zip Code)
ore,	es 1 and 2 of Health of Item 27 i		20a. Method of Disposition 20b. Place of Disposition cemetary cre	osition (Name of page) Memorial	Date 20c. Location - 0	City or Town, State
Baltimore, Maryland 21215-0036			1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Memorial 10/14	4/09 Salisbu	ry, MD
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Holloway Funeral Ho 501 Snow Hill Rd.,	ome Professiona Salisbury, MD	l Association 21804
8760,	Physician and physician and physician and physician and the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the princip	Exa	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	a		Approximate Interval Between Onset and Death
P.O. Box 68	eath certifi attending for use as	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date Mon	of delivery th Day Year
Division of Vital Records,	law requires that the deas been signed by the 2 should be detached	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contri	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
000	e law rec has bee e 2 shou	plete	Dissetes		24a. Was an 24b. W	ere autopsy findings available
Ä	The l	mo/			performed de	ior to completion of cause of eath? □Yes 2 □No
Vita	sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death		
of	Phys r this ral dir	<u>۱.</u>	1		me 5 Residence 6 Othe	
on	Attending Physician: If death. ector: After this certificity the funeral director, by	ig	27. Mann of Death 1	f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurre	d
Vis	r Atte er dea rector	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Street and Numbe City or Town, State)	r or Rural Route Number,
	urs aft					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, deal 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause(s) and mar ed at the time, date and place, a	nner as stated. nd due to the cause(s)
_	5 F F F F F F F F F F F F F F F F F F F	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
	VX/1		nurb	H005619-	7 10/11/0g	
	2 EV		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Sal. by MD 2186		
	Sta	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	7	
	Registra	ar	OCT 13 2000 Denus A.	parke		

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_			1 - State Amended date 10.13.0	Maryland / Dep. 9,SLU,WCHD _{Ce}	artment of F <i>rtificate of</i>	Health and N <i>Death</i>		eg. No. 2	009	34668
	Dharial		Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th		3. Time of Death
	Physici /Medio		Brenda Jean		Wallace		10	Day	Year	2157 M
The same	Examir		4a. Facility Name (If not institution, give street and number	ber)	4b. City, Town, o	or Location of Death			ty of Death	
mark .			Peninsula Legional mea	lical Center	5011	Shuru		11/1	(nmi	10
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Vaarl	9. Birthp	lace (State or Foreign try)
п	Director		219-60-2459 1□M 2፟ØF	57 Yrs.	Worlins Days	Hours Will.	9-26-1			vland
	pu »		Usual Residence of Decedent							
	shov	<u>-</u>	10a. State 10b. County	10c. City, Town or Lo	ocation				11	0d. Inside City Limits
	Ba-f	Director	MD Wicomico	Salisbury	7					1 □ Yes 2 汉 No
	or 2	Ë	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Coun	try?
	23a		305 Brookview Drive		218			USA	1	
	tems rems	Funeral	11. Marital Status 12. Was Deced Armed Ford	ent Ever in U.S. 13. es?	Was Decedent of H If Yes, specify Cubi	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, e	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. In Midcel Eventing must be notified at once.	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dat	ΧΊνο	1 □ Yes 21 No	Specify:	,	Speci		ite
21215-0036	tural	ed	15. Decedent's Education		dent's Usual Occup	pation		16b. Kind of E		
75	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retire	during most of work	ing	700. 11110 01 1	200111000,1110	dony
7	d with giene r tha	E	Elementary/Secondary (0-12) College (1-4		nistrativ	e Assista	nt	Clean	ing Co	ompany
b	il Hyg othe /ent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name				
Maryland	ild be fenta rked ric ev	To E	Herman Reece	Owens,	Sr.	Margaret		Jean	H	oppes
ar _Z	shound None	_	19a. Informant's Name/Relationship (Type. Print)			and Number or Run				
Ž	nd 2 alth a 27 is		Michelle Hudson - Daughte			re Drive,				
ē,	s1a of He item othe		20a. Method of Disposition	20b. Place of Dispo				20c. Location		
Ę	Page lent c nt: If ry or		1 ☐ Burial 2 【 Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	crematory Crematory		10 1/	4.09	D o 1 o	D - 1	
Baltimore,	mit. partm sorta / inju		21. Signature of Funeral Service Vicensee	/ CTelliatory	2. Name and Addre	ess of Facility Bot		Delmar	, Dela	aware
Ö	any per	t di	Melisa Fren Do	DQ. 7	05 E. Mai	in Street	unus run . Salish	erai n urv M	ome	nd 2180/
			23a. Part 1. Enter the disease, or complications that cau	ised the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	ar yrai	Approximate
and a	Physician		shock, or heart failure. List only one cause on each		VD					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or	as a consequence of):	V 12				_	
	Examiner			. ,						
1	P +	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):						
	ocute nd ransi	ami	that initiated events							
Ö,	tificate be executed g physician and as the burial-transit	Ä	resulting in death) Last Due to (or	as a consequence of):				_		
68760,	ate b hysic he bu	edical	d							
			IF FEMALE:					-1		
. Box	eath certific attending p for use as	an/l	23b. Was decedent pregnant 23c. If yes, outco	me of pregnancy th 2 Fetal death 3	☐ Ectopic pregnanc	ev.			ate of delive	•
0	e dea	sici	1 Yes 2 No 4 Pregna	nt at time of death 5	Other (specify)			M	lonth	Day Year
<u>Ч</u>	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/IV	9 Li Unknown							
<u>က်</u>	es that igned I be det	þ	Part II. Other significant conditions contributing to dear	th but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use cor	ntribute to th	e cause of death?
0.0	w requires t s been signe should be c	ted					1 ☐ Ye	s 2 No	3 Prob	ably 4 Unknown
Records,	e law r has bo	Completed					24a. Was ar		Were autop	osy findings available npletion of cause of
<u>~</u>	The laste has page	5					perforn	ned?	death?	
Vital	ician; Th certificate ector, pag	Be (25. Was case referred to medical examiner?			26. Place of Death		/	100	
-	hysic his or	2		oatient 2 🗹 ER/Outpatier	nt 3□DOA Oth	er: 4 🗆 Nursing Ho	me 5 🗌 Reside	nce 6 □Ot	her (Specify)
0	ng P	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of (Month,	Injury 28b. Time of Day, Year) Injury	f 28c. Injur Worl		28d. Describe ho			
20	eath.	gti	2 Accident investigation			Yes 2 □No				
Division of	or Att ter d irect n by 1	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	Injury - At home, farm, str , etc. (Specify)	eet, factory, office		28f. Location (Sti		ber or Rural	Route Number,
	ral o	OI								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the b	is of examination and/or in	h occurred at the tip vestigation, in my o	me, date and place, opinion, death occurr	and due to the cared at the time, da	ause(s) and nate and place	nanner as st , and due to	ated. the cause(s)
	thin ;	Med	one) and manne 29b. Signature and title of certific	stated.	29c. Licens			9d. Date sign		
	F > F 8		Jakad		HMX	19)	23	10 12		ruy, roarj
	1201	.	(Same)		1130	11/		10 112	,, - 7	
_	N. G.		30. Name and address of person who completed cause Chris Swyder 100 E	0- 1151	1	elis bun	mn	2180	/	
	Stat	e		istrar's Signatyre	let do	~13 1000	. ~!/	2 1001	*	
	Registra		OCT 13 2009 A	istrar's Signature						

9-08107				or Print in I						•	egible).	
loshua Todd Wi			State	e of Marylan					Mental	l Hygiene		201	20 0166
		1- For State Registrar	_		Cer	tificate c	of Deat	h			Reg. No.	20	
Physicia		1. Decedent's Nam	ne (First, Middle,L	ast)						2. Date of De	ath	Year	3. Time of Death
Medical Exami	ner		JOSHUA	TODD	WHITE:	SIDE				Month October			1454 hrs
1				give street and numb	er)				ocation of D	eath		County of Deat	
		4108 Locha	arrow Road				Perry	Hall			В	altimore Co	unty
Funeral		5. Social Security N	Number 6.	Sex 7.	Age (In yrs. I	ast birthday)		er 1 Year	If Under 2		Birth (MM/	DD/YYYY) 9. Bi Forei	rthplace (State or
Director		404-41-5	386	X M 2 F	20	Yr	Month s.	ns Days	Hours	Min. 10/03	/198	39	ountry) Kentucky
		Usual Residence o	of Decedent								•		
any		10a. State	10b. County		10c. City,	Town or Loca	ation			-			10d. Inside City Limits
and show	_	MD	Baltimo	re	Ba1	timore							1 Yes 2 X No
aryla at or	ector	10e. Street and Nu	ımber				10f. Zip	Code			10g. Citi:	zen of What Co	untry?
he M		8513 Cast	tlemill	Circle			212	236			USA	A .	
with the Maryland as 23a or 28a-f sho		11. Marital Status		12. Was Deced	ent Ever in U	S. 13. W	as Decede	ent of Hispa	anic Origin?	? (Specify Yes or N	lo-	14. Race - Ame	rican Indian, Black,
eath item	Funeral	1 X Never Marri	ied 2 Marrie	ed Armed Force	es?	If	Yes, speci	fy Cuban, N	Mexican, Pu	uerto Rican, etc.)	1	White, etc.	
fier d		3 Widowed	4 Divorc	ed If Yes, Give Year	Z A NO	1	Yes 2	X No	specify:			Specify: Whi	te
urs a itura	d by	15. Decedent's Ed	ducation (Specify	only highest grade	completed)					d of work done	16b. F	Kind of Business	/Industry
72 ho	ete	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)	during (most of wo	rking life. D	OO NOT use	e retired)			
D36 thin thin e.	Completed	12				stu	dent				5	student	
5-0 ed wi tygien of the M	Ö	17. Father's Name	(First, Middle, La	st)				18	.Mother's N	Name (First, Middle	, Maiden	Surname)	
215 De fillental H Red ent, 1	å	Raymond	B. Whit	eside					Laura	a Mae Par	ks		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	입	19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Maili	ng Address	S (Street a	and Numbe	r or Rural Route N	umber, C	ity or Town, Stat	e, Zip Code)
MD 12 sh 12 sh th an 127 i	Ì	Laura Ta	itum / mo	other		8513	Cast	lemil	ll Cir	rcle, Bal	timo	re, MD	21236
e, land Heal		20a. Method of Dis				Place of Disponder	osition (Na	me of ceme	etery,	Date		Location - City o	
nof		1 X Burial 2			State	11e Ha		•	rv	0/24/200	Q Re	11e Hav	en, Virginia
Baltimore, permit. Pages I ar Department of Hes Important: If ite	1	4 Donation 5			120			Address o	_	10,21,200		.O. Box	
Be Per Britis	ļ	1	VA	// 5	1	p	ought	v Fun	era1	Home, Inc			LYSTER OF
Physician	\dashv	23a. Pag. I. Enter th	he disease, or cor	mplications that caus	sed the death								Approximate Interval
/Medical	ļ		nly one cause on	each line. Methadone	into	xicati	on an	d fen	tanv1	use			Between Onset and Death
xaminer		Immediate Cause (or condition resulti	(Due to (or as a co									
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	ē	if any, leading to in	mmediate	Due to (or as a co	nsequence o	f):							
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and and transit		events resulting in	death) Last	Due to (or as a co	insequence o	11).							
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	ed.		<u> </u>		3a, 2/,	28a-r,	perm,	E g89	6 10/	/30/09 TT	Las		
OX 68760, sath certificate be attending physic for use as the bur	[]	IF FEMALE: 23b. Was decedent		23c. If yes, out			etal death	3	Ectopic p	rennancy	23	 d. Date of delive Month 	Day Year
x 687 th certific trending	Cia.	past 12 months	s?		t at time of de	noth -	Other (Spe		_ Lotopic pi	rograncy	1	THE STATE OF THE S	Day Tour
Boy e death the att	Physician/Med	1 Yes 2 I	No 9 Unkno	wn 9 Unknow	1		J. 101 (-)						
ion of Vital Records, P.O. Box 68760, rending Physician: The law requires that the death certificate be eath. or: After this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the buril		Part II. Other signi	ificant condition	s contributing to de	eath but not r	esulting in the	underlying	g cause giv	en in Part i	1. 23e. Did	tobacco	use contribute t	o the cause of death?
Signe be de	Completed by									1 _ Y	es 2	No 3 Pr	obably 4 Unknown
SCORDS, Records, The law requires are has been sig	eţe									24a. Wa			autopsy findings available
has le 2 st	림									per	opsy formed?	death?	
tal Recian: The certificate ector, page	3									1 ✔ Yes	2 N	1 🗸	Yes 2 No
Vital Rec ysician: The his certificate	a	25. Was case refer examiner?	red to medical	Hospital:				10	thor:	heck only one)	7	0 00	
of Vital B Physician Ther this cert meral directo	유	1 ✓ Yes 27. Manner of Deat	2 No	,	atient 2	ER/Outpatier 28b. Time of				Nursing Home 5		ence 6 V Oth	er: Scene
n of ding Ph. After tf	ä	1 Natural		28a. Date of (Month, Date of FOUND:	injury sy,Year)	FOUND:	i injury	28c. Injury	es 2 X N	i i	nk	ury occurred	
TE 8 8 8 8 8	崽	2 Accident	5 Pending Investig	ation Oct 18, 20	09	1441 hrs							
Division pital or Attendi ours after death. eral Director: /	ŭ	3 Suicide	6 X Could no	ot be		ome, farm, str	eet, factory	y, office bui	ilding, etc.			and Number or F ad, Perry Hall	Rural Route Number, City
E 6 6	Certification:	4 Homicide	determin	ned (Specify)	Single Far	nily				4108 Locha	rrow Ro	ad, Perry Hall	, MD
Divis the Hospital or A hin 24 hours after the Funeral Direc		29a. Certifier (Check only		ician: To the best o									
To the Hos within 24 h To the Fur completely	Medical			ner:On the basis of e and manner state	ed.	and/or investig				red at the time, da			
	Σ	29b. Signature and	title of certifier	/			29	c. License			29d.	Date signed (M	lonth, Day, Year)
	- }	Car	oe y	Hell	200			O.C.M	I.E.		0ċt	ober 19	, 2009
				o completed cause	,								
		Assistan	nt Medical Exa	aminer 111 F	enn Stree	et, Baltimo	re, MD 2	21201					
		31. Date filed (Moni			strar's Signati	ure 1	es						
Regist	rar		حمو 200	12	. A.	100 CR. 10	C. S.						

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ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of M		artment of Healt rtificate of Deatl		, 0	ne No. 2000	01676		
Physic	ian/	1. Decedent's Name (First, Middle					Date of Death Month	Day Year	3. Time of Death		
Med Exam		4a. Facility Name (if not institution	Elaine Zawat	sky	4b. City, Town, or Location	on of Dooth	October	13, 2009	9:45 a _M		
- LAGIII	iiiei	9709 Hillridge			Kensi			4c. County of Death	gomery		
Funera	•	5. Social Security Number		e (In yrs. last birthday)		der 24 Hrs. 8.	Date of Birth	9. Birti	hplace (State or Foreign		
Directo		103-20-8384 Usual Residence of Decedent	I - WI Z LOS F	83 Yrs.	Indiana Paye Hode	1711171	(Month, Day, Ye July 03,	1926	New York		
and show	ē	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
Maryl 28a-f otifie	Director		itgomery		Kens	ington			1 Yes 2 X No		
th the 3a or t be n		10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou			
ath wi	Funeral	9709 Hillridge	12. Was Decedent E	ever in ILS 13.1	Was Decedent of Hispanic		Vac or No-		S.A.		
ter de	ह	1 Never Married 2 Mar	ried Armed Forces? 1 ☐ Yes 2 🛣	No.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi		in, etc.)	14. Race - Amer Black, White			
OOG ours at tural"	Completed	3 🗷 Widowed 4 🗌 Divorced	Teal of Dates,		1 ☐ Yes 2 🗷 No Spec	city:		Specify:	White		
72 hc 72 hc Medic	Jale	Specify only highe	nt's Education est grade completed)	(Give	dent's Usual Occupation kind of work done during m O NOT use retired)	nost of working	16	b. Kind of Business I	ndustry		
212 within giene.		Elementary/Seconday (0-12)	College (1-4 or 5	i+)	Nurse			Health	icare		
Maryland 21215-0036 12 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Examir traumatic event, the Medical Examir	To Be	17. Father's Name (First, Middle, I	Last)		18. Mc	other's Name (Fir	st, Middle, Maid	den Surname)			
uld be marke			rael Horowitz				Sara Co				
Marylaı d 2 should be alth and Ments 27 is marked		19a. Informant's Name/Relationsi Carol Zawatsky		1.4	ng Address (Street and Nun 1990 Green Street						
1 and 1 and 1 item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Date		c. Location - City or 1			
Page Page ment cant dant dant dant M		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			con Cemetery 10/14/2009 Monmouth Junction, NJ						
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		21. Signature of Funeral Service L	icensee		Name and Address of Fac Hines-Rinaldi Fu						
		23a. Part 1. Enter the disease, or	complications that caused		11800 New Hampsh	hire Avenu	ie, Silve	r Spring, Ma			
- Ph. sician	,	shock, or heart failure. List	only one cause on each line	i the death. Do not ente	ar the mode of dying, such	as caldiac of les	piratory arrest,		Approximate Interval Between Onset and Death		
Medica		disease or condition resulting in death)		riosclerotic a consequence of):	Vascular Diseas	se			1		
Examine		Sequentially list conditions	b. Cong	estive Heart	Failure				1 month		
n z t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as t	в попянциилок обу							
xecuted and al-transi	Exal	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):							
icate be executed physician and sthe burial-transit	<u>ica</u>		d								
Attending Physician: The law requires that the death certificate be executed ar death. sctor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Medical	IF FEMALE:	1								
Box 687 death certificathe attending properties as the	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year		
O. B. t the dea by the a	hysid	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9 Unknown	. time or death 5 L	Other (specify)			Month	Day Tour		
S, P.O. ires that the signed by the	by P	Part II. Other significant condition	ons contributing to death be	ut not resulting in the u	nderlying cause given in Pa	art I.	23e. Did tobaco	co use contribute to	the cause of death?		
ords, v requires s been sig	ted	Diabetes Mellit	us				1 🗌 Yes	2 🗷 No 3 🗌 Pro	obably 4 🗌 Unknown		
Records, The law requires sate has been sig	Completed	Chronic Obstruc	tive Pulmonary	Disease			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of		
fital Rec sician: The la certificate ha irector, page 2		25. Was case referred to medical					performed		2 🗆 No		
Division of Vital al or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director,	To Be	examiner? 1 Yes 2 X No	Hospital:	ent 2 🗆 ER/Outpatien	- Other	eath (Check only	· ·	e 6 ☐ Other (Specif	.,		
Of V og Phys ter this neral di		27. Manner of Death 1 🗷 Natural 5 🗌 Pendin	28a. Date of injur	y 28b. Time of	28c. Injury at work?		Describe how in		у)		
r Attending F ret death.	Certificate:	2 Accident Investig	gation not be		M 1 ☐ Yes 2	□ No					
	Seri	4 Homicide determ		ry - At home, farm, stre . (Specify)	eet, factory, office		Location (Street City or Town, St	and Number or Rura ate)	l Route Number,		
DIVI: To the Hospital or A within 24 hours after fo the Funeral Dire completed filled in b	Medical	29a. Certifier 1 🔀 Certifying	Physician: To the best of	my knowledge, death o	occured at the time, date an	nd place, and due	e to the cause(s	and manner as state	ed.		
To the Ho within 24 To the Fu completed	Med	(Check 2 ☐ Medical E only one) 3 ☐ Certifying	xaminer: On the basis of ex Nurse Practioner: To the I	amination and/or invest	igation, in my opinion, death	occurred at the t	ime, date and pla	ace, and due to the ca	ause(s) and manner stated		
P Milt		29b. Signature and title of certifier	1111-	0.	29c. License number		29d.	Date signed (Month,	Day, Year)		
30		Muse	1/1/00	1 (200) = -		781		October 13	, 2009		
		30. Name and address of person with the second seco	who gompleted cause of deady, M.D., 4201	/		114W. Was	shington.	DC 20016			
St		31. Date filed (Month, Day, Year)	2. Registra	r's Signature	el d			_ 20020			
Regist	rar	OCT 15 2	UUY Kensun	1 p. 19 au	Company of						

09-08207 Anne Brumsted

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
State of Maryland / Department of Health and Mental Hygiene	2009	21.67
Certificate of Death	2007	3401

		1- For State Registrar				Ce	rtificate	of	Death				R	eg. No.	2	U U :	7 34	101	
Physicia	Physician / 1. Decedent's Name (First, Middle,Last) 2. Date of Death									Vear		ime of Death							
ledical Exami		Anne Adk	ins	Ann	e E	lfreth	Adkin	s					Month October 2				1311 hrs		
		4a. Facility Name (if not institution	on, give street	and nu	mber)		4t	. City, Tow	n, or Lo	ocation of	Death		4c. C	ounty of E	Death			
		5359 Colum	nbia Road			Columb	ia			Howard									
Funeral		5. Social Security	Number	6. Sex		7. Age (In yrs.	last birthday	/)	If Under 1	Year	If Under	24Hrs.	8. Date of Bi	rth (MM/DE)/YYYY) S		ice (State or F	oreign	
Director		216-54-9	9991	Yrs.	Months	Days	Hours	Min.	11/3	11/3/1955 Cou			Unknow	vn					
	ŀ	Usual Residence o	f Decedent	1 M 2								i							
any	ı	10a. State	10b. County			10c. City	, Town or L	ocatio	n							100	d. Inside City I	Limits	
* *	.	MD	Howan	rd		Col	lumbia									1	Yes 2 X	Z No	
Maryland 28a-f show 1 at once.	rector	10e. Street and Nu					-	\neg	10f, Zip Co	nde			1.	I0g. Citizer	n of What	Country?	,		
th the Maryland 23a or 28a-f sho	ě									•		,							
th the		5359 Columbia Rd. 21044 11. Marital Status											if 1/	USA	. D	A a! . a.a.	Indian Diad		
tems at be	uneral		ed 2 N	1 4	rmed Fo	orces?	J.S. 113		s, specify (0- 12	White,		Indian, Black,	'	
r dea or it	Never Married 2 Married Porces? 1 Yes, Specify Cuban, Mexican, Puento Rican, etc.) 1 Yes, Specify Cuban, Mexican, Puento Rican, etc.) 1 Yes, Specify Cuban, Mexican, Puento Rican, etc.) 1 Yes, Specify: Windows 4 X Divorced If Yes, Give Year 1 Yes, Specify: Windows 5 X No. Specify: Windows 5											-a .							
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hour matu Exan	þ	15. Decedent's E							s Usual Oc st of workin					IOD. KIII	id of busil	iess/indu	suy		
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	E	12		1			Home	mar	ter	Tac) & dadh anda	Nome /	irst, Middle,		n Hor	ne			
15- filed Hyg d oth	ပ	17. Father's Name	(FIRST, MIDDIE	, Last)									-irst, Middle,	Maidell St	urrianne)				
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Shoul Shoul N is m	٩															State, Zij	Code)	- 1	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once		David Ad		Broth	ıer	Look	. Place of Di						ork, I		cation - C	ity or Toy	ın State		
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™ §§ § ©	- 1	9	Part														MD 21	L043	
Physician		23a. Part I. Enter the				aused the deat	h. Do not en	ter the	e mode of o	lying, s	uch as car	rdiac or r	espiratory ar	rest, shock	k, or heart	. 7	Approximate In Between Onse		
/Medical		Immediate Cause				le drug	(coc	ain	e. me	tha	done	δ 0	lanzar	ine)		- 1	Death	Ct dilla	
caminer		or condition resulti		Due to	(or as a	consequence	of): into	oxi	catio	n	done		Landa	1110/				_	
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cuted and transit	۱Ä	events resulting in	death) Last	d d	(O) a 3 a	Consequence	01).												
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3760, ificate be g physici s the buri	<u>اچ</u>	IF FEMALE: 23b. Was decedent				outcome of pre pirth		Fet	al death	3	Ectonic	pregnan	cv		Date of deforth	elivery Day	Yea	ar !	
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Box 68 death certiful the attending and for use as	Physiciar	1 Yes 2	No 9 Un	known g	Unkno	own		_ 0	0. (=,,	′ —									
ch the		Part II. Other sign	ificant condi	tions contrib	buting to	o death but not	resulting in	the ur	nderlying ca	ause giv	ven in Par	t 1.	23e. Did	tobacco us	se contrib	ute to the	cause of deat	th?	
i, P.C ires that signed I be deta	d by												1 Y	es 2 🗸	No 3	Probab	y 4 Unkr	nown	
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of Vital ng Physician: After this certi	٩	1 V Yes	2 No		' 🗀	Inpatient 2	ER/Outpa			`			Home 5		ce 6 ✓		cene ————		
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Division tal or Attendi rs after death. al Director: /	흴	3 Suicide	6 X Cou	25	8e. Plac	e of Injury - At	home, farm,	stree	t, factory, o	ffice bu	ilding, etc	. 2	28f. Location or Town,		d Number	or Rural	Route Numbe	er, City	
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	4 Homicide	dete	ermined (S	Specify)	home						5			ia Ro	1. Co	lumbia	ı MD	
		29a. Certifier (Check only				st of my knowle													
To the within To the comple	Medical	one) 2	Medical Exa	miner:On the and m	e basis i nanner s	of examination stated.	and/or inve	stigati	on, in my o	pinion,	death occ	urred at	the time, dat	e and plac	e, and du	e to the c	ause(s)		
F \$ F 5	ž	29b. Signature and	title of certifi	er					29c. l	icense	number			29d. D	ate signed	(Month	onth, Day, Year)		
	1	O.C.M.E. October 23, 2009									2009								
	4	30. Name and add	ress of person	n who complet	ted cau	se of death (Ite	m 23a)												
		Laron Lock		•		al Examiner		enn	Street, E	Baltim	ore, ME	2120	1						
	ate	31. Date filed (Mon			32. R	∌ istrar's Signa	iture												
Regist			OCT 2	9 2009	1	Leave .	A	ha	del										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ocotber 27° 2009° Patricia Ann Addair 11:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Middle River Baltimore 1 Control Court 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Days Hours 06/23/1942 West Virginia Director 214-44-0858 67 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. Control Court 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 hours after If Yes Give 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Divorced 4 Divorced White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruby Ethel Lambert Headman May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2234 Hawthorne Road, Baltimore, Maryland 21220 Kenneth Addair (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)
Holly Hill Mem. Gard. 11/01/2009 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Ski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician sease or condition r sulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 use as IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has , page 2 performed? Yes 2 No Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation after death completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registr<u>ar</u> istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 28, 2009 1:40 P M LUCILLE CARTER BOWEN ALMOND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Lorien Assisted Living Bel Air 8. Date of Birth (Month, Day, Feb. 6, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F Kentucky 402-24-9326 91 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Bel Air Maryland Harford 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 21015 USA 1909 Emmorton Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Education 5+ Teacher of Health and Mental Hygie item 27 is marked other other other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (1 and 2 should be Lula Rowe Wade Galton Marshall Carter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 614 Camelot Drive, Bel Air, Maryland, 21015 Pamela Barrett / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 nent of H ant: If ite ary or ot 1 X Burial 2 ☐ Gremation 3 ☐ Re 4 ☐ Conation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or noval from State conation 5 Other (Specify) Monticello Memory Gdn. 10/31/09 Charlottesville, Virginia 22. Name and Address of Facility 21. Sign McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA END STAGE Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 😿 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DIABETES MECLITUS, STROKE HYPERTENSION, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No DSTEOPOROSIS autopsy performe Hospital or Attending Physician: The 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \hbfx\ Other (Specify) 1 Yes 2 No Assisted Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Living After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. UNION ANE, HAVREDE GRACE, MD 21078 MA 622 DHANJANI SUKESH 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar		State o	of Marylar		artmer <i>rtificat</i>			ınd Me		giene Reg. No.	0000	34674	
	Physicia	an	1. Decedent's Name (Fi	_		Anthony						2. Date of De Month	eath Day		3. Time of Death	
	/Medic Examin	cal	4a. Facility Name (If not	_	e street and nu	ımber)	-	4b. City,		Location of	f Death	2000	4c.	County of Death	30-1-	
مجتور	Funeral Director		5. Social Security Numb 357-12-046	er 6. S		7. Age (In yrs.		If Under Months	-	If Under 2 Hours	Min.	B. Date of Bir (Month, Da (uly 3)	rth ay, Year)	Coui	place (State or Foreign ntry) Illinois	
	D	or		cedent b. County nne Aru	nde1	10c. Ci	ty, Town or Lo	cation				<u> </u>			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
with the N 3a or 28a-		Funeral Director	10e. Street and Number	10f. Zip	Code					izen of What Coul	ntry?					
350	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event. In Medical Event har matt be neithed at	by Funera	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 🖔	edent Ever in U orces? 2 X No ive oates:		Was Dece If Yes, spe 1 □ Yes	**	spanic Orig n, Mexican Specify:	cify Yes or No lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
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lano 2	2 should be filed wo end Mental Hygie is marked other traumatic event.	To Be Co	17. Father's Name (Firs Frank Rocci				2000	Liter	у орс	18. Mothe	r's Name	(First, Middle	, Maiden	Surname)		
, Mary	₽ = 1 7 = 1	-	19a. Informant's Name/ Ms Carolyn			ghter						Route Numb		or Town, State, Zij 21122	p Code)	
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pall	permit Pages Department of Important: If it any injury or once.		21. Signature of Funera	la MI	1.4		1280s	Servi	ces I	PA 1 2	2nd A	ve. Gl	len B	eral & Cr Surnie MI	21061	
	Physician /Medical Examiner		23a. Part 1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List only	one cause on	each line.	PONIC	_			0		4 £	DISEASE	Approximate Interval Between Onset and Death	
icate be executed physician and the burial-transit		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d													
O. BOX 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 mor	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No										23d. Date of delivery Month Day Year		
ras, r	quires that en signed b uld be deta	þ	Part II. Other significar	nt conditions o	contributing to	death but not res	sulting in the u	nderlying	cause give	en in Part I.	_				the cause of death?	
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DIVISION	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the fune	Certification: To	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num. City or Town, State)									nd Number or Rui e)	lumber or Rural Route Number,			
10	the Hospit in 24 hour he Funers pletely fills	edical											e, date an	use(s) and manner as stated. e and place, and due to the cause(s)		
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			30. Name and address	BATO	30	Registrar's Stan	m 23a) (Type,	Print)	رب		The	n Bw	ruce	e mus	20161	
	Sta Registi		31. Date filed (Month, L	9 2009	Deven	r logistiai s 3011	A SOL									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34675 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FREDERICK ALEY ALLAN October 27, 2009 12:10A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1XXM 2 - F July 10 1921 South Carolina **Director** 043-18-6103 88 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XX/es 2 No Maryland | None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 825 Lenton Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces 3, 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ White 1 Yes XX No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Investments Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allan III James Miriam Alev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Leslie Allan 825 Lenton Avenue Baltimore, Maryland 21212 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State GreenMount Crematory Oct 28,2009 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) e Lice see 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc gnature of Funeral 6500 York Road Baltimore Maryland 21212 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only of Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy perform Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 10 V 30. Name and addr of person who completed cause of death (Item 23a) (Type, F

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itemale30 penter than \$8 95 epte trae it of the alth and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1-50AM **Physician** /Medical 4b. City, Jown, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** - 1timore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State Baltimore 1 Ses 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship Baltimore, IND 21229 Baltimore, Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Baltimore, and 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 10/31/09 Donation 5 Other (Specify) ure f Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner ena) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans for as a consequence of) Box 68760, physician Physician/Medical the attending pl 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy the Hospital or Attending Physician: The 2 A No 1 ☐Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To After this funeral c 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier moran H Mallin

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State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 34677 Certificate of Death Reg. No 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23, Physician BOSCH ELIZABETH Μ. OCTOBER 2009 5:20P M /Medical 4c. County of Death BALTIMORE 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death RASPEBURG Examiner 5633 DAYBREAK TERRACE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 218-16-2399 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 12-29-1919 9. Birthplace (State or Foreign Months 1 □ M **20**4 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location RASPEBURG 1 ☐ Yes 2 No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U.S.A. 5633 DAYBREAK TERRACE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2√□No Specify. þ Specify: WHITE XXWidowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES FLORIST 18. Mother's Name (First, Middle, Maiden Surname) WILLAMENA (UNI 17. Father's Name (First, Middle, Last) Be (UNKNOWN) **HERMAN** KRUSE မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5633 DAYBREAK TERRACE BALTIMORE, MD 21206 JOSEPH SELWAY/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL MEMORIAL CARDEN: 10-27-09 MIDDLE RIVER, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee ROSEDALE, MD 21237 1211 CHESACO AVE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARCINOMA 6. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 21. No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform FIBRILLATIN 1 □Yes 2 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ★Natural 2 ☐ Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760, physician the burial signed by the attending particle by the detached for use as certificate has lirector, page 2 s this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Funeral

Director

id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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Department of H
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any injury or ot

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State

Medical

29a, Certifier

30. Name and addr

31. Date filed (Month,

29b. Signature and titled certif

Registrar

DHMH 17 Rev 1/2001

e of death (Item 23a) (Type, Print)

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918 RIDGE RO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BATTIMORE, MARY/400

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 445 9 M IRMA BUTCHER Physician PATRICIA 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER 8. Date of Birth (Month, Day, Yea 8-26-1940 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min MARYLAND 1 □ M 2 👽 F 69Yrs 218-36-7121 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MIDDLE RIVER **FALTIMORE** MD 1 □Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1306 GUN POWDER CROSSING LANE 21220 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic months. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) HANRAHAN MADELINE CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122019a. Informant's Name/Relationship (Type. Print) 1306 GUN POWDER CROSSING LANE MIDDLE RIVER, MD KIM BUTCHER /DAUGHTER Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-29-09 CATONSVILLE, MD METRO CREMATORY 4 □ Donation 5 □ Other (2pecify) 21. Signature of 5 neral Se Ac. Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ROSEDALE, MD 21237 1211 CHESACO AVE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (4r as a consequence of): **Physician** /Medical Examiner Stage Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Exami Tobacco and attending physician and for use as the burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 5 Other (specify) Ö ed by the detached 9 Unknown 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ∐Yes 2 X No 1 ∐Yes 2 DaNo Hospital or Attending Physician:
 Ahours after death.
 Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completely filled to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

以 State

To the I within 2

Registrar

31. Date filed (Monthy Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BURTON

32. R gistrar's Signature

29c. License number

5401 OLD COUNT ROAD RANDMISTOWN MD

29d. Date signed (Month, Day, Year)

October 25 2009

09-08136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **Omari Cotton** 2009 34679 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 20, 2009 0400 hrs Medical Examiner Omari Cotton c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Northwest Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 11-19-2008 Country MD Director 216-83-6599 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1 Yes 2 No or items 23a or 28a-f show must be notified at once. N/A Balto with the Maryland rector 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 3031 E. Biddle Street ö 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X Yes Black Yes 2 X No specify: Specify. 4 Divorced If Yes, Give Year more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) infant Infan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lakeshia Williams marked event, t Corey Cotton Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is a Biddle Street Balto, MD 21213 3031 E. Jenet Artis-Social Worker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: I Randallstown, 10-29-09 King Memorial Pk Donation 5 Other Specify March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death /M_dical Cardiac arrhythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Cardiac disease Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and hysician/Medical **X** UNPENDED **AMENDED** the attending physician ed for use as the burial PI line a-b, 27, per ME g900 2/9/10 TT the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown signed by the be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown ð Completed Records, 24a. Was an 24b. Were autopsy findings available page 2 should certificate has been prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital | funeral director, Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 Other: DOA Inpatient 2 V ER/Outpatient 3 this 1 Yes No ٩ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification Yes 2 No 1 X Natural n 24 hours after death. ie Funeral Director: A letely filled in by the fu Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. completely filled in by 3 Could not be or Town, State) Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME October 20, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Kem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 32. Registrar's signatural

State Registrar

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month Day State Registrar

Ana Rubio MD.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signa

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

October 24, 2009

09-07689 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 34681 State of Maryland / Department of Health and Mental Hygiene Bobby James Depew, Jr. 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1114 hrs **Medical Examiner** Bobby James Depew, Jr. October 3, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Woodbine Carroll 7032 Woodbine Road 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours 231-19-5673 Director 1 X M 2 F 42 Yrs 07/19/1967 Tennessee Usual Residence of Decedent 0d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 No MD Howard Columbia event, the Medical Examiner must be notified at once, within 72 hours after death with the Maryland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5122 West Penfield Road or items 23a or 21045 United States Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married Yes 2 X No Yes, Give Yaar Yes 2X No specify: 3 Widowed 4 Divorced Specify: White "oatural", ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) timore, MD 21215-0036

it. Pages I and 2 should be filed within 72 h
rment of Health and Mental Hygiene.
react: If item 27 is marked other than "o College (1-4 or 5+) Vertical Transportation 12 Construction Specialist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Williams Be Bobby James Depew, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shawnna Depew, Wife 5122 West Penfield Road, Columbia, MD 21045
of Disposition (Name of cametery. | Date | 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holston View Cemetery 10/09/2009 Weber City, Virginia rtaot: 4 Donation 5 Other Specify 21. Si mature of Juneral Service Licensee 22. Name and Address of Facility Harman Funeral Service, PA T. Harman 7221 Grayburn Drive, Glen Burnie, MD 21061 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a Head and Neck Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED ending physician a The law requires that the death certificate be 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Day Fetal death 2 past 12 months Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown P.O. as been signed by t should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease, chronic alcohol abuse Completed Records, certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 28a. Date of Injury FOUND: Day, Year) 5 28d. Describe how injury occurred After Manner of Death 28b. Time of Injury 28c. Injury at Work Subject down steps 1 Natural **FOUND** Division Pending 1 Yes 2 ✔ No death. within 24 hours after death To the Funeral Director: the Oct 3, 2009 1103 hrs 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 5122 W. PennField Road, Columbia, MD determined (Specify) a residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Che one) Medical 2 Widedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and tit 29c License number

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAZO GALLELE NO

Assistant Medical Examiner

B. Jak

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 4, 2009

Registra

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cei	rtificate of	Death		Reg. No.	109	34683
	Physici	an	1. Decedent's Name (First, Mic JOHN BURLIN		.				2. Date of D	r 26,200	າດ ^{Year}	3. Time of Death 10:41A M
	/Medic Examir	cal	4a. Facility Name (If not institute Broadmead		imber)		4b. City, Town,	or Location of De		4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 212–38–4949	6. Sex ▼▼ M 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days	If Under 24 H				place (State or Foreign ntry) / I and
			Usual Residence of Decedent									
	arylane show		10a. State 10b. Cour	nty	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	a-fs	cto	Maryland Balt	imore	Cock	keysvil	le					1 □Yes 2 💢 💆 o
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 13801 York Ro	ad			10f. Zip Code 2103			10g. Citizen d		ntry?
9	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modicel Exaction must be rediffed at once.		11. Marital Status 1 Never Married 2 M	Axmod E	edent Ever in U. orces? 2 NWWI		Was Decedent of If Yes, specify Cu 1 □Yes XX N	Hispanic Origin? ban, Mexican, Pue Specify:	(Specify Yes or I erto Rican, etc.)	No- 14. F	lace - Ameri lack, White, Whit	oto
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7 a	d be ental ked o	To Be	George William De					Pearl	Burling			
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6-09 Baltimore.	ages 1 an ant of Hea		20a. Method of Disposition 1 Burial Cremation	n 3 🗆 Removal from	State Gree	Place of Dispo cemetery, crei	sition (Name of matory or other p. Crematory	ace) Oct	Date 28,2009	20c. Location		
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26 B	90 F # 9		MMMD X 44	arangen	OKIS				k Road Ba		Marylan	
0		1	23a. Part 1. Enter the disea shock, or heart failur L	or complete ins that ist only ne cause on	caused the deat each line.	th. Do not en	er the mode of d	ying, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due t	(or as a conseq	juence of):	dis	(7			
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12	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	≺		,,.					1	
10	icate be executed physician and the burial-transit	Exa	resulting in death) Last	c	(or as a conseq	juence of):						
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68760	ertificate be executed ding physician and se as the burial-transit	Medical										
O. Box	Attending Physician: The law requires that the death certific ector: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	atcome of pregna birth 2□ Feta gnant at time of a nown	aldeath 3	☐ Ectopic pregna ☐ Other (specify)				Date of deli Month	very Day Year
Di a	ires that signed b	무	Part II. Other significant cond	litions contributing to c	leath but not res	sulting in the u	nderlying cause	given in Part I.	23e. Di	d tobacco use c	ontribute to	the cause of death?
√ sp	v requires been sign	d by	Conglist	ve her	ext	101	lune		_ 1[∵Yes 2 🗸 🗖	3 □ Pro	obably 4 🗌 Unknown
eco	e law requ has been le 2 shoulk	Completed	Aortic	insu	ffici	inc	W		24a. W	topsy	prior to c	topsy findings available ompletion of cause of
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n	ding F h. After funera	lë E	1 ☑ Matural 5 ☐ Pen		nth, Day, Year)	Injury	W	ork? □Yes 2 □No	EGG. DOGGIE	o non many oo	, a.i.o.a	
) Division of Vital Records	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 Suicide 6 □Cou		e of Injury - At h	I ome, farm, sti fy)	reet, factory, offic			n (Street and Nu Fown, State)	mber or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir.	Medical C	29a. Certifier 1 Certific (Check only one)	ying Physician: To the all Examiner: On the and mai	e best of my kno basis of examina nner stated.	owledge, deat ation and/or ir	h occurred at the evestigation, in m	time, date and play y opinion, death o	ace, and due to to ccurred at the tin	he cause(s) and ne, date and place	I manner as ce, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of cert	ifler		11-	29c. Lice	nse number		29d. Date sig	ned (Month	Day, Year)
			13drloa	ra Ca	Stall	6/2	7 1	7383	92	10/	261	2009
	12V		30. Name and address of pers	on who completed cau	ise of death (Iter	23a) (Type,	Print)					
	100		BARBARA	CHRRO	211,	M, D.	,1380	1 VOR	KRD	·, COCK	EX	VILLE, MI
	Sta	ate	31. Date filed (Month, Cay, 2e	9 2009 32/2	legistrar's Signa	ature		,			1	

			State of Maryland / Department of Health ar State State Certificate of Death	nd Ment			0 21.601.
	_		1. Decedent's Name (First, Middle, Last)	2. Di	Reg ate of Death	. No. 200	3. Time of Death
н	Physici		Deborah A. Everette	M	/lonth	Day Ye 200	ar and an
	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I			4c. County of D	• 1
-	LXaIIIII	e	FRANKLIN Square Hospital Rosedala	e		13aL7	imore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Min (A	ate of Birth Month, Day, Y	(ear)	Birthplace (State or Foreign Country)
ı.	Director		218-62-5127 57 Yrs. 57	8	-30-1	952	MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryli f sho	Ď	MD N/A Baltimore				1xXYes 2 □ No
	the t	Director	10e. Street and Number 10f. Zip Code		10g	g. Citizen of What	Country?
	3a o	a D	1606 Ralworth Road 21218			USA	
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Exercity at mark to rediffed at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	in? (Specify Y	Yes or No-		merican Indian, /hite, etc.
36	or ite		1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 No Specify:		.,,	Specify:	Black
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Exprining Industrial Larrutified at once.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Street and Number of				
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altimore,	ges 1 If of F If ite or ot		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date		oc. Location - City ansdow	
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Ва	perm Depa Impo any i	į ,	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. Nort		rch	East Balto,	
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca				Approximate Interval Between
=	Dhysisian	i n	shock, or heart failure. List only one cause on each line.				Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Concessive Heart failur Due to (or as a consequence of):				4
	Examiner		Cheance obstructive Pulmo	onary	dis	, e a s €	
	p ±	ner	She unnticity list oundfill may if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	,			
/	ecute and trans	Examiner	that initiated events c.				
90,	be ex cian a ourial-		Due to (or as a consequence of):				
687	equires that the death certificate be executed een signed by the attending physician and louid be detached for use as the burial-transit	dical	d				
×	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	delivery
Вох	death e atter	iciar	in the past 12 months? 1			Month	Day Year
P. 0	at the de by the stached	hysi	9 ☐ Unknown				
S,	ss tha gned oe det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2			te to the cause of death?
ord	w equires to the standard be a	ed			1 ☐ Yes	2 No 3	Probably 4 nknown
ec	law as b	ple		2	24a. Was an autopsy performe	24b, Wer	e autopsy findings available r to completion of cause of
<u> </u>	The	Completed			performe 1 □ Yes 2 [ed? deat	h? Yes 2 No
Vita	sician: The certificate h rector, page	Be	examiner?		neck only one)		
ot	Phys r this ral dir	.T	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nurs			ce 6 Other (Specify)
on	ding P. h. After funera	tion	27. Manner of Death 1		Describe non	mjary occurred	
Division of Vital Records,	l or Attend after death Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. L	Location (Stre	eet and Number of	r Rural Route Number,
6	al or s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)	'	City or Town,	State)	
,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death				
	To the H within 24 To the Fi complete	Medical	one) and manner stated.				
•	vitl Con	2	29b. Signature and title of certifier Let Hausthil M. D. 29c. License number 56919	ich		d. Date signed (A	- ,
			10111	0	0	112	R,21,200°
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN H 9000 FRANKLIN SKUARE DRIVE, BA	4617	MOR	E, MA	RYLAND
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, - ,			/
	Registr		OCT 29 2009 Product A. Bark				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g896 10-29-09 vt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 3 3 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ctober /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Florida 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF a Yrs. Director Usual Residence of Decedent 10a. State Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is an exted other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Mever Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) ondary (0-12) College (1-4or 5+) dervice 18. Mother's Name (First, Middle, Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number City, or Town, State, Zip Code) Watts Road, Owings Mills, OND 21117 Baltimore, 20c. Location - City or Town State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State Woodlawn, MD 21. Signatur of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) ELVEDERE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical October Joseph Η. Fuchs, Jr.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Examiner		2101 Tred			arribory			Esse		Location	oi Deaui			:. County of Dea Baltimo:	
Funeral	5	5. Social Security No	umber	6. Sex		e (In yrs. la	st birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	9. Bi	rthplace (State or Foreign
Director	L	213–16–35		1 X M 2 □			88 Yrs.	WOITINS	Days	Hours	IVIII1.	09/02/	<u> 1921</u>	Mar	yland
ind show		Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	cation							10d. Inside City Limits
laryla Ba-f s tiffed	I	Maryland	Balti	more		Ess	sex								1 🗆 Yes 2 🔀 No
the N a or 2 oe no	1	10e. Street and Nun	nber	-				10f. Zip	Code				10g. Ci	itizen of What C	ountry?
leath with the Maryland items 23a or 28a-f she er must be notified af Funeral Director	Ŀ	2101 Tred	Avon	Road				2	1221					U.S.A.	
r iter	1	11. Marital Status		12. Was D	Forces?	194	2- 13.	Was Deced If Yes, spec	dent of His cify Cubar	spanic Ori n, Mexicai	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
al", or Examin		1 Never Marri		If Von		No 194	15	1 🗌 Yes	2 🔀 No	Specify				Specific	nite
vithin 72 hours a iene. Ir than "natural" the Medical Exa	r	/Pao		nt's Education			16a. Dece	dent's Usu					16b. k	(ind of Business	
nin 72 ne. han " e Mec	ŀ	Elementary/Seco	onday (0-12)	est grade complet College	(1-4 or 5	5+)	life. D	kind of wo O NOT use	rk done d e retired)	uring mos	t ot work	ing	Ϊ.,		
led with Hygier other tent, the		17. Father's Name (12	(nat)			Plum	ber		40.11.11				umbing	
d be file Mental I arked o rtic eve		Joseph H.		,								e (First, Middle efferna		Surname)	
d 2 shoul alth and 1 n 27 is ma er traums		19a. Informant's Na Vera Fuch						-					-	r Town, State, Zi Maryland	•
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	2	20a. Method of Disp 1 X Burial 2 4 Donation	☐ Cremation	3 ☐ Removal fr Specify)	om State	Cé	ace of Disponentery, creations	natory or c	ther place			Date 0/2009		ocation - City of	r Town, State Maryland
permit. Departn Importe any inju		21. Signature of Fur	ner	Adensee			2:	2. Name ar	nd Addres Br						A. yland 21221
	Ť	23a. Part 1. Enter the	he disease, or	r complications th	at caused	d the death	. Do not ent	er the mod	e of dying	g, such as	cardiac o	or respiratory a	rrest,	CA, PRIL	Approximate Interval Between
Physician/		Immediate Cause (diseas or conditio	Final	only one sauce on	Caori iiri	N	uta	stat	10	C	MCI	noung			Onset and Death
Medical Examiner		resulti in death)		aDue	to (or as	a consequ		1.00			7 0 0				
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ed sit min	ı	if any, leading to im cause. Enter Under Cause (Disease or	rlying	Dille	to to as	a consequ	ence only								
n and all-tra	ı	that initiated events resulting in death) I		c. Due	to (or as	a consequ	ence of):								
hysicia he bur	ı			d											
ding p	h	F FEMALE:		23c. If yes,	outcome	of pregnar	nev								
that the death certificate be executed need by the attending physician and a detached for use as the burial-transit by Physician/Medical Examiner	2	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 □ Li 4 □ P	ve Birth	2 Fetal	death 3	☐ Ectopic ☐ Other (sp	pregnanc pec <i>ify)</i>	у				23d. Date of de Month	Day Year
8 8 8		Part II. Other signif	icant conditi	ons contributing t	o death b	out not resu	ulting in the I	ınderlying	cause giv	en in Part	l.	23e, Did	tobacco	use contribute to	o the cause of death?
0	- 1											123	Yes 2	□ No 3 □ F	Probably 4 🗆 Unknown
2 20 1												24a. Was auto perf		prior to	utopsy findings available completion of cause of
ertificat ector, pe Be Co		25. Was case referre	ed to medical						26. Pla	ace of Dea	th (Checi	1 ☐ Yes k only one)	2 A N	o 1	s 2 No
hysici		examiner?	K No	Hospital:	☐ Inpati	ent 2 🔲	ER/Outpatie	nt 3 🗆 D	OA Othe	er: 4 🗆 N	ursing Ho	ome 5 Res	idence (3 ☐ Other (Spe	cify)
. offer the uneral		27. Manner of Death 1 X Natural	n 5 ☐ Pendi	/8.	ate of inju Jonth, Day		28b. Time o injury	2	8c. Injury work	?	- 1	28d. Describe	how injur	y occurred	
or Attending P after death. Director: After t In by the funera Certificate:		2 Accident 3 Suicide		gation not be				M	_	Yes 2	No	201			10 11
rs after al Directed in by		4 Homicide	detern			ary - At noi c. (Specify)	me, farm, str	eet, factory	/, опісе			28f. Location (City or To			ıral Route Number,
To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sig completed filled in by the funeral director, page 2 should be Medical Certificate: To Be Completed It		(Check 2	Medical I	Physician: To the Examiner: On the Nurse Praction	basis of e	xamination	and/or inves	tigation, in	my opinio	n, death o	ccurred at	t the time, date	and place	e, and due to the	cause(s) and manner stated.
With Com		29b. Signature and	title of certifie	uhr	M			290	: License	number 350	18		29d. Da	ate signed (Mont	th, Day, Year)
	-	30. Name and addre	ess of person	who completed c	ause of d	eath (Item	23a) (Type, I	Print)	alpr	nici	Roa	id C	BA.	mp	21237
State Registrar	3	31. Date filed (Monti	DCT 2	9 2009 32	. Registra	ar's Signati	ure A.	park	1						

Paul Nathani	el	Ford	L. F All C			-1-	
09-07342 UNK UNK		Please Type or Print in Black Indelible In State of State			i re ∟eg ii ene	oie.	
		1- For State Certificate of Registrar			Reg.	No. 200	0 21.6
Physicia	n/	Decedent's Name (First, Middle,Last)			ate of Death onth D	ay Year	3.7 ime of Death 0 0240 hrs
Medical Examir		PAUL NATHANIEL FORD 4a. Facility Name (if not institution, give street and number) 4	b. City, Town, or Location		onth D eptember 1	9, 2009 4c. County of Death	02401115
		44. Facility Name (if not institution, give street and number) 809 Kayak Avenue	Capitol Heights	Of Death		Prince George	's
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Und	er 24Hrs. 8. l	Date of Birth(MM/DD/YYYY) 9. Birti	nplace (State or
Director	ļ	212-08-5082 1 N 2 F 45 Yrs.	Months Days Hours		9/6/19	Cou	Cheverly Intry) MD
		Usual Residence of Decedent					10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location	on				1 X Yes 2 No
ryland a-f she t once	io	Maryland Prince George's Capitol Ho	eights 10f. Zip Code		10g.	Citizen of What Coun	try?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Ex miner must be notified at once.	Director	616 Nova Ave.	20743		IIn	ited State	S
with t	ral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Ori		Yes or No-	14. Race - Ameri	
death or item	Funeral	1 Never Married 2 Married 1 Yes 2 X No	es, specify Cuban, Mexicar	т, Риепо кісаг	n, etc.)		
s after ral", o	اھ	or Dates:	Yes 2 X No specify t's Usual Occupation (Give		1000 11	Specify: B1 6b. Kind of Business/li	ack
hour:	ted		ost of working life. DO NOT		ione	op. Kind of Business/i	luustiy
336 thin 72 than than	Completed	12 Landsc	aper			Private	
5-0(led wi Hygier other		17. Father's Name (First, Middle, Last)	18.Mothe	er's Name (Firs	t, Middle, Ma	iden Surname)	
21215-0036 old be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Joseph Fredwood Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Hele Address (Street and Nu	n mbos es Busel	Douto Numbe	or City or Town State	Zin Code)
MD 2 d 2 shoul lith and M m 27 is m aumatic	리		Huckle Berry				
e, M and 2 lealth item 2 traun		20a. Method of Disposition 20b. Place of Dispos	ition (Name of cemetery,	Dat	te 2	20c. Location - City or	Town, State
nord ages l at: If		1 X Bunal 2 Cremation 3 Removal from State crematory or off 4 Donation 5 Other Specify: Harmony		10/16	/2009	Landover,	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Harmony 1 21. Signature of Funeral Servical icensee 22. N	Name and Address of Facili	tyPope 1	Funera	1 Homes, P	.A.
E P E		Kotthe a Harry MOINTS 155.	38 Marlboro	Pike Fo	orestv	ille, Mary	land 20747
Physician /Medical		23. Fart I. Enter the sase, or completions that caused the death. Do not enter the failure. List only one cause on ach line.	he mode of dying, such as	cardiac or resp	piratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of pelvis Due to (or as a consequence of):					Death
		Sequentially list conditions, b					
	iner	if any, leading to immediate Due to (or as a consequence of):					
lsi e kd	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
	_	d					
0, be ex	edic	UNPENDED				23d. Date of deliver	
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ector	oic pregnancy			Day Year
ox 6 ath cer attendi	sicia	4 Pregnant at time of death 5 Ot	ther (Specify)				
the de	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in F	Part I.	23e. Did tob	acco use contribute to	the cause of death?
tal Records, P.O. B rian: The law requires that the d certificate has been signed by the ector, page 2 should be detached	ð				1 Yes	2 ✔ No 3 Pro	bably 4 Unknown
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e faw te has ge 2 si	dwo				perform 1 ✓ Yes 2	ned? death?	_
al Ro an: Tl ertifica tor, pa	Be C	25. Was case referred to medical	26.Place of Deat	h (Check only	F-1-4		
Vital I hysician: this certifi al director,	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		Nursing Ho		tesidence 6 🗸 Othe	r: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	ü	27. Manner of Death 1 Natural 5 Pending Pending 28a. Date of Injury 28b. Time of FOUND: POUND: 28b. Time of FOUND:	Injury 28c. Injury at Wo	– Isul	i. Describe ho bject shot	ow injury occurred	
IVISION or Attend after death. Director: in by the	cati	2 Accident Investigation Sep 19, 2009 0240 hrs Sep 19, 2009 0240 hrs 28e. Place of Injury - At home, farm, stre			Location (St	reet and Number or R	ural Route Number, City
Divis	Certification:	3 Suicide 6 Could not be determined (Specify) Vacant Home	,		or Town, Sta		
포작물링		29a. Certifier 1 Certifying Physician To the best of my knowledge, death occu	rred at the time, date and p	place, and due	to the cause	(s) and manner as sta	ted.
To the Hos within 24 h Completely	Medical	one) 2 Medical Eximine: On the basis of examination and/or investigated and manner stated.			e time, date a		
7 5 5 6	ž	29b. Signature and title of certifier	29c. License numbe	er		29d. Date signed (Mo	
			U.C.IVI.E.			Coptember 18, a	
OCME		30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 11	1 Penn Street, Baltin	more, MD	21201		
	tate						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 34688 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 26, 2009 Feimer 5:30 AM Peter Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heart Homes Lutherville Baltimore Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🛣 M 2 🗆 F Months Days Hours July 20, Director 213-12-9991 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2 XNo MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 U.S.A. 42 Mansion Road 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ William Feimer Susanna Hemerka permit. Page 1 and 2 should Department of Health and M Important: If item 27 is ma any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Susan Gallagher/Daughter 206 Ambleside Drive SevernaPark Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 31 cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licen MO1580 Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus ach line. Onsel and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Du la or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 ANo Ssisted P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death con 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Watural injury 5 Pending 2 No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 25205 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 18

Registrar
DHMH 17 Rev 7/2009

State

Registrar

For State

			Registrar			Cer	tificate of L	Jeath		R	eg. No.	109	34007
	Physici /Medic		1. Decedent's Name (First, Middle, Las DIANE EL	IZAB	ETH		GRAN	T		2. Date of Dear	2 ^{Day}	2009	3. Time of Death 1635 M
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of	f Death		4c. Cour	nty of Death	
×			Howard County Gene	eral Hospi	tal		Columb					vard	
	Funeral Director		5. Social Security Number 8. S 217–42–2176	ex 7. Age □M 2. XTF	(In yrs. last birth	rs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day lug. 24	Year) 1944	9. Birthp Coun Mary]	lace (State or Foreign try) Land
	and w		Usual Residence of Decedent 10a. State 10b. County	· -	10c. City, Town	or Loc	ation					110	0d. Inside City Limits
	laryla sho	5		-									1 □ Yes 2√2 No
	the N	ect	Maryland Baltimo	ore	Winds	or	Mill 10f. Zip Code			1	On Citizen	of What Coun	
	with a or	₫	9045 Old Court Roa	1			2124	/.				_	,
	ns 23	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V			nin? (Sne	cify Yes or No-		ed Sta	
0	fter d r iten	Funeral Director	1 □ Never Married 2 □ Married	Armed Forces? 1 ∐Yes 2XN			las Decedent of Hi Yes, specify Cuba	n, Mexican	, Puerto F	Rican, etc.)		lack, White, e	
25	urs a al'',o Evar	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 2⊠No	Specify:			Spe	^{cify:} Whit	:e
9500-51212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Department of Heath and Mentall Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Medical Evaning must be notified at once.	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. I	Deced	ent's Usual Occupa	ation	of workin		16b. Kind of	Business/Ind	lustry
7	ithin ne.	Jdr.	Elementary/Secondary (0-12)	College (1-4or 5-	-) [ind of work done of NOT use retired			'y			
2	led w lygier her th	ပ်	12		G	ene	ral Accou				Feder		vernment
yland	be fill hall hall hall hall hall hall hall h	Be	17. Father's Name (First, Middle, Last)							(First, Middle, I	Maiden Surn	ame)	
Ž	d Mel d Mel nark	2	James Grant		1.01			Mani		Harold	-		
Mai	d2sh than 7is r traur		19a. Informant's Name/Relationship (,			Address (Street a						ŕ
<u>ရ</u> ်	1 an Heal em 2	-	Brenda Williams/ 20a. Method of Disposition	Sister	20b. Place of I	H) (Dispos	old Court ition (Name of atory or other place	Road	, Wi	ndsor M	111, Ma 20c. Locatio	ryland n - City or To	1 21244 wn. State
٥	ages ent of t: If It		1 ☐ Burial 2 🔯 Cremation 3 🗆		1		-	· .	2009	£ 20,		•	•
saitimore,	nit. P artme ortan injur		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Metro (ire1	matory, 3			nation (Baltin	nore, M	Maryland aryland, Inc
n n	lmp any		Amarch He		Caston	29	9 Frederi	i ola Da	oren	Dolain.	octer	y ol Ma	iryiand, inc
	- T		23a. Part 1. Enter the disease, or comp	olications that caused	the death. Do no	ot ente	r the mode of dyin	g, such as	cardiac o	r respiratory arr	est,	arylan	Approximate
- F	hysician		shock, or heart failure. List only immediate Cause (Final	one cause on each line		7	CEM	A					Interval Between Onset and Death
100	/Medical		disease or condition resulting in death)	a Due to (or as a	consequence of								
~	Examiner		Conventiolly list conditions	G	TANG!	RE	NOUS	R	1G+	17 L	EG		
^	D #	Examiner	Sequentially list conditions, if any, reading to intringulate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of		2 6 9	1 / -	· · · · ·				
8	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last		CUBI		72 0	LE	IR2				
09/90	e law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit		s	Due to (or as a	consequence of): -(} -	RAL	VA	-5 (1	DLAR	DIS	37/E	
ğ	cate physi the t	n/Medical		.d	-/ (/ /)		,,,,,,				4-)(
XO	certifi iding se as	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy								
מ	atter for u		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at	E Fetal death	3□	Ectopic pregnancy Other (specify)	/				Date of delive Month	Day Year
j .	Attending Physician: The law requires that the death rideath. Adeath. Adeath. Ector: After this certificate has been signed by the after by the funeral director, page 2 should be detached for the funeral director.	Physicia	1 □ Yes 2 Mo 9 □ Unknown	9 Unknown		0 _	Other (opcony)						
T	s that ned b deta		Part II. Other significant conditions of			the un	derlying cause give	en in Part I.		23e. Did to	bacco use co	ontribute to th	ne cause of death?
ecords,	quires n sign	d by	HYPE	カトライン	11011					1 □ Ye	9s 2 No	3 ☐ Prob	ably 4 Unknown
ပ္ပ	sw rec	Completed	END STAC	ie re	MAL	_	DITE	ASE	3	24a. Was a	n 24	b. Were autor	psy findings available
֓֞֟֝֟֝֟֝֟֝֟֝֟֝	he la te ha age 2	E O		, , ,						autops perform	ned?	prior to cor death?	npletion of cause of
VITAI VITAI	sician: The certificate rector, pag	o i	25. Was case referred to medical					26 Place	of Death	1 □ Yes (Check only on	2 (21%) o	1 □ Yes	2 L No
>	ung Pnysician: The h. After this certificate h. funeral director, page	.0 B	examiner? 1 ☐ Yes 2 ∑XO No	Hospital:	nt 2 ER/Outs	atient	3 □ DOA Othe	or:		ne 5 🗆 Reside		Other (Specify	v)
5 6	aling Ph	n: T	27. Manner of Death	28a. Date of Injur (Month, Day)	y 28b. Ti	me of ury	28c. Injury Work	y at		8d. Describe ho			,
0 .	endir ath. or: Af	atic	Natural 5 Pending investigation		reary my	ury		Yes 2 □!	No				
DIVISION	r Attraction by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farr (Specify)	n, stre	et, factory, office		2	8f. Location (Si City or Town	reet and Nu	mber or Rura	l Route Number,
ָ	urs af urs af ral D								1,4				
	Io the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examination and	death /or inv	occurred at the tin estigation, in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ded at the time, d	ause(s) and late and plac	manner as s e, and due to	tated. the cause(s)
, 	vith To t	Ž	29b. Signature and title of certifier		PHYSI	CFA	29c. License D (Trint) Swrc	number 0 6	270	2	9d. Date sig	ned (Month, I	Day, Year) 7 2009
	0		30. Name and address of person who	completed cause of de	ath (Item 23a) (T	ype, F	rint)		E	LL^cat+	C't's	IM	21043
	٧		3290 N	Kidge	ROA	d,	2 mrc	100				,	- / -

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) QCT 29 2009

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Heatwolk Year **Physician** 20 001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Northwest UDSP. tal andallstown Bal turnor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25, 1956 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1⊠M 2□F 53 Director 216-68-8980 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ir than "natural", or items 23a or 28a-f sho 1 □Yes 2 □ No Director Maryland Carroll Sykesville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1222 Seron Court 21784United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Programmer Federal Government is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any injury or other traumath 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Heatwole 2 Lois Marie Emswiler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4476 Woodsman Drive #1012, Hampstead, Maryland 21074 Renee Heatwole/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 29. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending | for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 ☐ Yes 2 📮 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗀 Yes ≥ ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number completed cause of death (Item 23a) (Type, Print) 5401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 29 2009 Registrar

10*

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

2

2

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

October 23, 2009

State of Maryland / Department of Health and Mental Hygiene 2009

			1 - State Registrar		(Cert	tificate of L	Death	F	eg. No. Z	009	34692
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		Edward Parker	Jones, Sr.					octobe		2009	2020M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4c. Co	ounty of Death	
* /			Season's Hospice				Randall				Baltimo	
	Funeral		5. Social Security Number 6. Se	x 7. Age ≩M 2□F	(In yrs. last birth	- //	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Coun	
M	Director		218-48-6585 Superior State of December 18	•	63 Y	rs.			7/29/19)46	Mar	yland
000	À.=		10a. State 10b. County		10c. City, Town	or Loca	ation				1	0d. Inside City Limits
May	fsh	ঠ	MD Worchest	er	Snow Hi	11						1 ☐ Yes 2 🔀 No
å	28a	<u>3</u>	10e. Street and Number	.02	D.70 130		10f. Zip Code			I0g. Citizer	n of What Coun	try?
with	3a o	Funeral Director	4612 Pennewell Ro	ad			21863			U	.S.A.	
44	ams 3	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	as Decedent of Hi	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14.	Race - Americ	
₹ و	or ite	F	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 ⊠No			Tes, specify cuba □Yes 2⊠No	Specify:	riicari, ctc.)	S	Black, White, e pec <i>ify:</i> W	nite
G Z1Z13-UU36 filed within 72 hours after death with the Maryland	ıral",	d by	3 Widowed 4 X Divorced	Year or Dates:								
Z15-0036 hin 72 hours aff	"nat	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted</i>)	(Give k	ent's Usual Occupa ind of work done o O NOT use retired	during most of work	ing	16b. Kind	of Business/Inc	dustry
Mit i	than	дшс	Elementary/Secondary (0-12)	College (1-4or 5+) '		Mechanic)		Auto	motive	
	Hyg other ent, I		17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Su	rname)	
yland yldbe file	ked (To Be	Albert			Jo	ones	Dora				Sturgis
ary shou	md N mar	-	19a. Informant's Name/Relationship (7)	pe. Print)	19b. I	Mailing	Address (Street a	and Number or Rui	al Route Numbe	r, City or T	own, State, Zip	Code)
, E	alth alth 27 is	1	Edward Jones, Jr	•	11	.0 5	South Was	shington	Street,	Snow	Hill,	MD 21863
	of He		20a. Method of Disposition		20b. Place of D	Dispos	ition (Name of atory or other place	e)	Date	20c. Loca	tion - City or To	wn, State
Page	ant: If	. 3	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)		1		ts Registr	i	7/2009	Hano	ver, Ma	ryland
Saithmor	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinar must be notified at once.		21. Signature of Funeral Sance Lichs	ee		22.	Name and Addres	ss of Facility An	atomy G	ifts	Registr	У
ם פ	29 2 2 2	(0	1 500		- 1		7522 Conr	nelley Dr	., Ste.1	Р, На	nover,	MD 21076
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused t ne cause on each line	he death. Do no	t ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	nysician	'n	Immediate Cause (Final disease or condition	Med	astat	10	Basa	1 Cell	care	unon	1G	Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	consequence of):	1000 200 000			1077	e-(
	Aanmei	<u>.</u>	Sequentially list conditions,	0.	*****							. —
o be	sit	Examiner	day, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	odneaquanos of,							
	and Il-trar	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of):	· · · · · · · · · · · · · · · · · · ·					
6 8	sician			,		,						
x co/out	g phys	Medical		d								
	anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy					230	d. Date of delive	ery
death o	e atte	sician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2	ime of death		Ectopic pregnancy Other <i>(specify)</i>	4			Month	Day Year
j e	by th tache	Phys	9 Unknown	9 Unknown								
S. Te	gned se de	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in t	he und	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to the	ne cause of death?
ecords, law requires t	en si ould t								1 □ Y	es 2 🗌	No 3 ☐ Prob	pably 4 L Unknown
law r	as be 2 sh	plet							24a. Was a		24b. Were auto	psy findings available mpletion of cause of
r e	ate h page	Completed							perfor	med? 2 No	death? 1 □ Yes	
VILGII	n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Be (25. Was case referred to medical examiner?					26. Place of Deat		ne)		
Physic V	this c	은	1 Yes 2 No		t 2 ☐ ER/Outp			4 LI Nursing H	ome 5 🗆 Resid		Other (Specif	gons Hospice
	After	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,		ne of ury	28c. Injury Work	(?	28d. Describe h	ow injury o	occurred	
SION	tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be	loo. Division (1)				Yes 2□No	006 1 10 10			10
or Ai	Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At nome, farn (Specify)	n, stre	et, factory, office		City or Tow	treet and r n, State)	Number or Hura	al Route Number,
pital	ours ours filled		29a. Certifier Certifying Phy	sician: To the best of	mv knowledge	death	occurred at the tin	ne, date and place	and due to the	cause(s) a	nd manner as s	stated.
e Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical		ner: On the basis of and manner state	examination and							
To the	within To th	Me	29b. Signature and title of certifier	2 ,			29c. License	e number	:	29d. Date s	signed (Month,	Day, Year)
	-		Ill rellie t	seulon			H45	5931		Octo	ber a	20 2009
			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (T	ype, P	rint)		0 :	2010		•
	,		Ur Dabb	16 Bursto	n 5,4	101	OLD CO	VRT Rd	Kanda	Visto	un M	0
	Sta Registr		31. Date filed (Month, Day, Year)	009 32. Registrar	's Signature	14	ante					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2144 PM OCTUBER YNNHOL JUNES L. 28 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW MEDICAL CENTER HOPKINS BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 🔀 M 2 🗆 F 66 Yrs. 10/17/1943 North Carolina 239-68-3482 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Director Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 949 Lance Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes **X**No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XXXIo Specify: Specify:White þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th Trucking Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Jones Foye George ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 an. Department of Heath. important: if item 27 any injury or other traonce. Dona K. Richardson (Friend) 949 Lance Avenue, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 10/29/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Immedial ause (Final diseas or condition resulting in death) **Physician** 2 DAYS RESPIRATURY FAIWRE /Medical Due to (or as a consequence of): Examiner UNENDAN Now snow CELL LUNG CANCER STAGE IV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician the burial Box 68760; Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4 ☐ Pregnant at time of death 5 Other (specify) P.0. □Yes 2□No the ped 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? cate has page 2 s performed certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural after death.

Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral Hospital 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES US 1 OCTOBER 28,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEAN HEFFERNAN MD BALTIMORE MO 4940 EASTERN AVENUE, 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ SNECK 5.40PM 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Avalanche 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2**X** F Months Hours January 6,1948 220-48-3258 60 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and it. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2XX No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21044 11214 Avalanche Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🖪 No Black, White, etc. 1 Never Married 2 Married þ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marion Miller John Allen Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21223 518 Sunset Road Scott A. Jesneck (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 10-30-2009 Brentwood, Maryland Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, Maryland 21045 5555 Twin Knolls Road or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Myorardial infaction Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner ia bet Sequentially list conditions, Examine cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant a Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate I 1 Yes 2 No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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10710 Charter Drive Str 440 Columbia MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 27, 2009 Physician OCTOBER KARDIAN 8:50P M JOHN V. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE IVY HALL NURSING FACILITY MIDDLE RIVER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-18-1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1**X** M 2 □ F Hours MARYLAND 217-20-1143 83 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Experiment he notified at BALTIMORE 1 ☐ Yes 2 XNo MD ROSEDALE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 21237 5 CRESTVIEW GARTH U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð Specify: 3 Widowed 4 Divorced Year or Dates: 1944-46 WHITE Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than' Elementary/Secondary (0-12) 12College (1-4or 5+) MILLWRIGHT LOCHEED MARTIN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOSEPH** KARDIAN ANNA (HRNCIR) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tra 21237 JANET CLARA KARDIAN/WIFE CRESTVIEW GARTH ROSEDALE, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH : 10-31-09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fund 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) oronas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has briector, page 2 sl autopsy performed 1 ∐ Yes 1 ∐Yes 2 ∐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records, or Attending Physician: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; A completely filled in by the fu r death.

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lol Ohh

and manner stated.

D.O.

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier

31. Date filed (Mo

Battimore Mace Ave

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month SAMES KING OCTOBE 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALT IMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) H05P Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 421-36-5559 15 M 2□ F Months 1932 la Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 □Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working jife. DO NOT use retired) 16b. Kind of Business/Industry ocke Elementary/Secondary (0-12) College (1-4or 5+) ILTS 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n611, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Junes -Rd eto eonne daughler 649 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 95 □ Other (Specify) -09 DWINGS MILLS, MI) 22. Name and Address of Facility 1md, 2,229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Sepsis MANGRAM Due to (or as a consequence of): nted with low ejection fraction ar siomyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury DEMENITIA that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 F 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modest Event her court by nothered

is marked other

permit. Pages 1 and 2 sf Department of Health and Important: If item 27 is n any Injury or other traun

Baltimore, Maryland 21215-0036

Exami

ending physician and use as the burial-tran

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Division of Vital Records,

Physician/Medical attending properties for use as been signed by the should be detached þ Completed page certificate I Be Certification: To

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

State Registrar 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEEMA 3001 50U Registrar's Signatur 31. Date filed (Month, Day, Year) 29 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCHOOCI **Physician** 7:48 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altimore Baltimore City Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Min 1 □ M 2 🖳 F Yrs. .0/18/1946 Director 212-50-0512 Marvland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shorted Mcdical Examiner must be refilled at 1x Yes 2 □ No Director Baltimore City MD MD Baltimore City

10e. Street and Number 10g. Citizen of What Country? 21218 717 E 37th Street USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any injury or other traumatic event, train any once. Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Bruce Long Earlean Donelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 E 37th Street, Baltimore, Jacqueline Long/Daughter MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services | 10/29/2009 | Hanover, MD 21. Signature of Funeral Service Licensee Ardent Cremation Services Drive, Ste. N, Hanover, MD Tama C. Hardesto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) P.O. s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No 24a, Was an certificate has page 2 autopsy performed' 1XYes 2□No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation (Year) To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21287 Wolfe Street Michael Minder MN Emile lobb 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 7:00 ambert October Kalph 27 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HUSPITA Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Director 3/28/1935 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County r items 23a or 28a-f show 1 ☐Yes 2 No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 41 Coolbreeze Drive S. Funeral 21220 A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: 1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ö 1 ☐ Yes ≱☐ No Specify traumatic event, the Medical Ever-\$ 3 ☐ Widowed 4 Divorced 1966 "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Man Brewery marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Sheridan Lambert Carolyn Victoria Bowles Department of Health and Important: If item 27 is ma any injury or other traumat once. 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Coolbreeze Drive Middle River, Maryland 21220 e of Disposition (Name of Date 20c. Location - City or Town, State Ralph_Burl_Lambert_(Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 10/28 2009 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multi System disease or condition resulting in death) 01961 /Medical Due to (or as a consequence of): Examiner End Stage read
Die to (or as a consequence of): Sequentially list conditions, if any, leading to influed the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Alconolic cirrhosis Due to (or as a consequence of): 68760. Physician/Medical Aspiration Dreumonia Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, icate has been siç 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

JORDAN

MD

Q 0()

32. Regist ar's Signature

30. Name and otheress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

street, Baltimor

29d. Date signed (Month, Day, Year)

October

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Jean Ethel Lucas 23, October 2009 10:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛛 F 79 Director Jan. 29, 1930 292-30-0690 Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1205 Mazeland Drive 21015 USA Funeral 14. Race - American Indian. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: δ White 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Paul Babincky Margaret (nmn) Hamza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart Lucas / Son 1205 Mazeland Drive, Bel Air, Maryland, 21015 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake Park Cemetery 10-29-09 Youngstown, Ohio 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland, 21:009 23a. Part1. Enter the disease, or complications that caused the death shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 40 Cardial del CUT 6 /Medical Due to (or as a consequence of): Examiner C) 41 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ (DUCTOR -1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28a 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 66342 10/23/09 Kapil Patel, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HESATEAKE 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 34700 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ronald Jerome October 26°, 2009°' 6:00 Mason рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's 762 Kimberly Way Stevensville 5. Social Security Number g. Birthplace (State or Foreign Country) Ohio 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Days Hours Min. Now 8 Day, Years 7 220-34-3881 71 **Director** Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27.7 is marked outber than "natural", or items 23a or 28a-f sho any injury or or other traumatic event, the Medical Examiner must be notified at any injury or puter traumatic event, the Medical Examiner must be notified as 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Queen Anne's Maryland Stevensville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21666 762 Kimberly Way United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Building Superintendent Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Georgianna Scutter Walter J. Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis A. Mason/ Wife 762 Kimberly Way Stevensville, Maryland 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Juneral Service License Cremation Society of Maryland, 299 Frederick Road Baltimore, Alice Iser Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End stage liver disease Onset and Death MON LNS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Alcoholic Cirrhosis Sequentially list conditions, if any, and grown grown grown cause. Enter Underlying Cause (Disease or iinjury that initiated events Disc to for sels consciousnes of Exami attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be .24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death ned by the a e detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by s been signe should be c 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has I autopsy perform 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🖫 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. within 24 hours after death

To the Funeral Director. /

State Registrar (Check only one

nd title of certifie

James Chamberlain, M.D. 115 Sallitt Drive Stevensville, Maryland 21666 31. Date filed (Month, Day, Year)

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

10/27/09

29c. License numbe

D37064

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 Myrtle Irene McKenen October 10:30 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown NMS Healthcare If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** West Virginia Days Hours Min. 1□ M 2 F 0472771922 87 236-22-4600 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Washington Smithsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 United States 14109 Edgemont Road · death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 White Specify: <u></u> Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Abbott Bessie (Not Known) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James A. McKenen (Son) 14109 Edgemont Road, Smithsburg, Maryland 21783 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery | 10/21/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Last only one cause on each line.

Immediate Cause (Final Physician MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tryR072181 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Nes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Flva Month 09:50 AM 9 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Aug • 3, 1922 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 185-14-8515 87 **Director** Aug. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7642 Hennesey Court 21061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates Page 1 and 2 should be filed within 72 hournment of Health and Mental Hygiene. tant: If item 27 is marked other than "natuury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Circuit Checker <u>Westinghouse</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stewart Mary Ellen Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Mary Lou Rosencranz/Daughter 7642 Hennesey Court Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of h October 1 XBurial 2 Cremation 3 Removal from State Important: If any injury or Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Brooklyn Park, MD 21. Signatu of Funeral Privic Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services PA 1 2nd Ave.SW Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Myocarchal Physician disease or condition resulting in death) Medical as a consequence of Examiner o de Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown a 🗌 Unknown ģ signed to Part II. **Other significant conditions** contributing to death but not res*u*lting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 1 Yes director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ To 24a. Was an has autopsy performed Yes 2 After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 FA/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year, 0033296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) feld RD Glen Bunnemp 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Francis

29c. License number D42892

Little Patuxent Parkway Columbia MV 21044

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quidian

MD

10724

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** OCTOBER 24, 2009 6:45AM PORTER COLUMBUS **JARVIS** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 7801 PENINSULA EXPRESSWAY APT. 203 DUNDALK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours **™** M 2□ F 11/28/1924 VA 212-20-8041 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at ¥XYes 2 □ No Director DUNDALK BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number "natural", or items 23a or dical Examiner must be USA 21222 7801 PENINSULA EXPRESSWAY APT. 203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Xes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XXMarried 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the SHIPPER BETHLEHEM STEEL 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY COPELAND DAVID R. PORTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7801 PENINSULA EXPRESSWAY APT.203 BALTIMORE, MD LILLY PORTER/WIFE item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any injury or off 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MARYLAND ARBUTUS MEM. PARK 10/30/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 21217 BALTIMORE, MD 1701-31 LAURENS STREET 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEAR Physician RENAL FAILURE disease or condition resulting in death) /Medical Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed' 2K No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

the Maryland

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

BALTIMORE VAMC State Registrar

29b. Signature and title of certifier -

oured keay

10 N. GREENE ST. BALTIMORE, MD 21201 32. Registra 's Signa ure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONRAD MAY, M.D.

M.D.

DHMH 17 Rev 1/2001

29c. License number DO032186 29d. Date signed (Month, Day, Year)

10-27-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Reg No. 2009 34705 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 27, 2009 Kyle Ross 12:32 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Franklin Square Hospital Rossville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours Min. 218-46-8022 62 Yrs 0373071947 Virginia Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9727 Bird River Road 21220 U.S.A. hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 1966 Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Steel Manufacturer is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Kyle Ross Reba Alma Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Julia Ross (Wife) 9727 Bird River Road, Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. 11/02/2009 Baltimore, Maryland 21. Signa Licensee 22. Name and Adgess of Actionski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final dise e or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Day 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy death? Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: A
id in by the fu Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Certifying Nurse Practioners To the best of my knowledge, death on

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) adelphia RD, Suit 300 BATTO NO 21237

d at the fine, date and place, and due to the

29d. Date signed (Month, Day, Year) 10-27-2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician -AIRE 11:40 PM TOBE 2 26,200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTMORE 15 N. ROLLINGROAD ALDINGUIDIA. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/07/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🛣 F 85 216-14-4602 Maryland Director Usual Residence of Decedent 10d, inside City Limits 10c. City, Town or Location in and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show its marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15 N. Rolling Road 21228 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ∐Yes 2 MX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Transportation Secretary or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John P. Oppitz Clara Sauer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Arthur L. Rhoads - Husband 15 N. Rolling Road Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) New Cathedral Cemetery 10/29/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Par T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** ballation 700 Sequentially list conditions, Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of sician and burial-transit Due to (or as a consequence of) certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. 9 Unknown q | Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed acluse 1 ☐Yes 2 ☑No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direct 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29c. License number 30631 451000 address of person who completed cause of death (Item 23a) (Type, Print) en 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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		1	State Registrar Decedent's Name (First, Middle	/ oot)		Cer	tificate of l	Death		eg. No. 2 U	09	34708
Physic		/	Lawrence	Rayno	· ~				2. Date of Death Month October	Day	Year	3. Time of Death
Med Exam	dica nine		a. Facility Name (if not institution			0 1	4b. City, Town, o	r Location of Dea	th	4c. County		16.0
. 4			Baltimore Was		Medical	Conter		4	Burnie	Au	me	Arunde/
Funer Directo	_		Social Security Number	6. Sex 1 2	7. Age (In yrs. 74	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min		935	9. Birthp Count Balt	olace (State or Foreign trx) IMOTE, MD
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r deatl			. Marital Status 1 ☐ Never Married 2 🔀 Mari	Armed Fo			Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - Americ k, White, e	
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nd 21215-0036 flied within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	1	L – 1		nt's Education est grade completed)	(Give k	ent's Usual Occup	during most of wo	orking	16b. Kind of Bu	ısiness Inc	dustry
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ING 21213-UU36 e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		_	7. Father's Name (First, Middle, L	.ast)			-	18. Mother's Na	ame (First, Middle, M	aiden Surname		
Maryland 2 should be filed th and Mental Hy 27 is marked ott traumatic even!	1	_	dwin A. Raynor			-			line V. Jo			
			9a. Informant's Name/Relations $^{\circ}$		hter)				ural Route Number, alethorpe,			
IMORE, Page 1 an ment of He ant: If iten ury or othe		20	Da. Method of Disposition 1 Burial 2 Cremation	3 Removal from	20b. I	Place of Dispos cemetery, crem	sition (Name of latory or other place Ige Memor	e) - 1 10 /	Date :	20c. Location -		·
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	oj l	21	4 ☐ Donation 5 ☐ Other (S	Specify)	Ме		Name and Addre		28/2009 Full Black Files	Elkridge	<u> </u>	
any any	ouc		Vay Dy	melin	>>>	41	07 Wilke	ens Aveni	ue, Baltin	nore, M	aryla	and 21229
			3a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on e	caused the dear	h. Do not ente	r the mode of dyir	ng, such as cardia	c or respiratory arres	st,		Approximate Interval Between
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box death c death c ed for u	Dhucioisu/Mo		in the past 12 months? 1 Yes 2 No	1 🔲 Live	Birth 2 Fet gnant at time of	al death 3 🗌	Ectopic pregnand Other (specify)	су		Moi	e of deliventh	Day Year
that the coned by the detache			9 Unknown			sulting in the u	aderlying cause di	ven in Part I	22a Did tob		ibu da da dh	e cause of death?
Ords, P.O. Box 687 v requires that the death certifics been signed by the attending p should be detached for use as t	Pro Pro	3					idenying educe gr			s 2 \square No		~ /
VITAI RECOIDS, ysician: The law requiree is certificate has been sig director, page 2 should b	Completed	high							24a. Was an	/	rior to cor	osy findings available mpletion of cause of
OT VITAI FECO Physician: The law r r this certificate has be aral director, page 2 si			- 184						perform 1 \(\sum \) Yes 2		leath?	2 <u>N</u> o
/Ital	T B	5	5. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	unpatient 2 □	EB/Outpotion		er:		2 D Oth		
OT N ng Phy fter this			7. Manner of Death 1 Natural 5 Pendin	28a. Date		28b. Time of injury	28c. Injur	y at	Home 5 Resider 28d. Describe how			
ttendii death. stor: Af	Cortificator		2 Accident Investig	gation			M 1 🗆	Yes 2 No				
al or Attendin s after death.	2	2	4 Homicide determ		ing, etc. (Specif		et, factory, office		28f. Location (Stre City or Town,		r or Hural	Houte Number,
DIVISION OF VITAL RECORDS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	logical	29	(Check Z Medical E	xaminer: On the ba	sis of examinatio	n and/or investi	gation, in my opinio	on, death occurred	and due to the caus l at the time, date and lace, and due to the d	l place, and due	to the cau	ise(s) and manner stated.
To the within To the compl	2		b. Signature and title of certifier	1/ 1/1	A A	, morriedge, d	29c. Licens	e number	29	d. Date signed	(Month, E	Day, Year)
		_	Vadem y	rakles	V, MI	/.		8240	(Uctob	er	24,2009
		1	Name and address of person work	hov 3	301 He	spital	Drive	, Glen	Burnie	MD	21	24,2009
S [.] Regis	tate trar		. Date filed (Month, Day, Year)		gistrar's Signa	ture B. A.	arke			′		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 05 Scott 24 DRMA -200 /Medical 4a/Facility Name (If not institution, give street and number of ARKWAN CTR 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE BALTMORE NO If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) Days 1□ M 2 F Months Hours Min. 214-25-8578 Usual Residence of Decedent 82 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 → No Director MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1400 ROSEWICK AVENUE 21237 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: Specify: WHITE ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER TELEPHONE COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM ZITTEL FLORENCE MARY (FORD) 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BETTY LOU MUELLER/SISTER 7805 WINTERHAVEN ROAD ROSEDALE, MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 10-29-09 BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Jamer en ce Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heim 715 /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit 13 Due to (or as a consequence of) P.O. Box 68760, physician IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1∐ Yes 2 1No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 🗙 No 1 ☐ Innatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, within 24 hours a completely

> State Registrar

Medical

29b. Signature and title of certifier

NM

RNP 1801 WALTHER gistrar's Signature 31. Date filed (Month, Day, Year) 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RO8910

29d. Date signed (Month, Day, Year)

2+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Madeline Theresa Schneck /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner n/a 7. Age (In yrs. last birthday) If Under Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours 218-01-7489 95 Director July 7 1914 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be redified at Director 1 ☐Yes 2 No Baltimore Parkville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8800 Old Harford Rd. 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No white Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper / Concessioner 9 Concession n/a is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth M. Doscher George Bieber Injury or other traumatic ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 9505 Buckhorn Rd., Baltimore, MD 21234 Shawn Millet/grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Kuria! 2 Cremation 3 Removal from State Pikesville, MD Druid Ridge Cemetery 10/30/09 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility
Lemnion Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Fune Service Licenses Michael 23a. Part 1. Enter the di leas shock, or heart fail re. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** CHANGE , MADINITINE Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Day to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 D Fetal death
D Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate l performed 1 □Yes 2 □No Division of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔲 မှ 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident investigation 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral F filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the I 29c. License number

15857 U

29d. Date signed (Month, Day, Year)

October 24 2009

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Taman, fan Hisp. Il Bultimore 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marianne Frances Taylor 9:45 P M October 26, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Anne Arundel Harwood If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday, Date of Birth (Month, Day, Months Days Hours Min. 1 □ M 2 🕱 F 11/9/1951 215-64-2943 57 Arizona Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Elmwood Court 21012 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Activity Director Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sayre Curran Elizabeth Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan G. Taylor/ Husband Elmwood Court, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 10/28/2009 | Hanover, Maryland 4 ☑ Donation — 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21061

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Experiment heart filed at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed by

Be 2

cate has t s after death.

I Director; Af filled in by

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List on	y one cause on each line.	50 Hot enter the mode of dying, such as card	nac or respiratory arrest,	Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. CANCIEN Due to (or as a consequen	PANCHAS		Onset and Death 2/2 + FANS
Sequentially list conditions, if any least immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence) d.	ne ofji:		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacco	
			- 24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence	620 Other (Specify) 140 US
27. Manner of Death	28a. Date of Injury (Month, Day, Year)	b. Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		farm, street, factory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier Certifying F (Check only 2 Medical Ex-	Physician: To the best of my knowle aminer: On the basis of examination and manner stated.	dge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	ace, and due to the cause(scurred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
29h Signature and title of certifier	_	29c License number	20d D	ate signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATICINS

NNMULIS

900 BESTERTERA

32. Registrar's Signature

OCTUBER 27, 2009

21401

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2 1/21/21 Nancy Tegtmeier 11:30AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Baltimore Center CHAISON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Sept 25 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Maryland 213-38-8518 **Director** 67 Sept Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant if if item 27 is marked other than "natural", or items 23a or 28a-f sho ant if item 27 is marked other than "natural", or items 23a or 28a-f sho ury or or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Parkville 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8320 Old Harford Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Catholic Charities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Mckelvey Sterling Leese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1718 1./2 Wycliffe Avenue Parkville, Maryland21234 Patricia Rozankowski/ Daughter 1718 1/2 Wycliffe Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 28, 1 Durial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MULTILOBAR PNEUMONIA Medical Due to (or as a consequence of): Examiner NEUTROPENIA Gausentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed hours after death. s been signed by the attending physician and should be detached for use as the burial-trans <u>MULTIPLE MYELOMA WITH BONE METASTASE</u> that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsete \text{No} \) Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, æ 26. Place of Death (Check only one) 12 Other: 2 X No 1 🗌 Yes 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24034

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 2 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #12, per FH G896 10/29/09 TT
State of Maryland / Department of Health and Mental Hygiene

1- State Amend 1 & 4c, per MD & 12,16a,18,&19a, per FH G897 11/18/09 TT
Registrar

Registrar

Reg. No. 200 1. Decedent's Name (First, Middle, Last) Viola Stroud Tolbert 2. Date of Death Day Month Year **Physician** Viola CTOBER 2009 <u>Tolbert</u> /Medical 4c. County of Death
Prince George's 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Doctors Community Hospital anham 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M **X**[X]F Hours Min 88 075-20-2169 Director 08 - 19 - 21Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. Important: I I fam 27 is marked other than "natural", or items 23a or 28a-f show any injun; or other traumatic event, the Medical Exprising reast to other traumatic event, the Medical Exprising reast to other traumatic event, the Medical Exprising. Director 1 □ Yes 🏋 💢 No PA NA Philadelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1817 W. 73rd. USA Funeral Avenue 19126 12. Was Decedent Ever in U.S. Armed Forces?

Tayles No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc African 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes XXNo Specify. ^{Specify:}American þ 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) 12th Grade Administrative Assistant Veteran College (1-4or 5+) NA Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Stroud Ida Mae Stroud Washington 2 19a Informant's Name/Relationship (Type Print)
James C. Tolbert, Jr
James C. Tolbert -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12719 Quarterhorse Drive Bowie, MD 20720 ace of Disposition (Name of Date 20c. Location - City or Town, State Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Sepulchre Cem. 11-7-09 Chelteham, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications it all caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Andiac disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Chronic and certificate be execu Due to (or as a consequence of) burial-Box 68760. Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Yea Day 5 Other (specify) P.0. the 9 Unknown þ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ Autery 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2000 Division of Vital 1 □ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 M Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 27th 2009 Tuchtel 5 MDD52865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelson M. Figaro, MD
31. Date filed (Month, Day, Year) 32 12700 Goodloes Promise Drive Bowie, MD 32 Registrar's Signatu State 29 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 25, 2009 George A. Upperco 4:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 24 Yorkview Drive Timonium 8. Date of Birth Sept. 20,1948 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Months Maryland Director 217-48-8930 61 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Yorkview Drive 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 X Married Š 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland Department of Elementary/Seconday (0-12) Health & Mental Hygiene Health Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Albert L. Upperco Mildred Lucille Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly M. Upperco/Wife 24 Yorkview Dr. Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 2009 4 Donation 5 Other (Specif Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Flagle Michael 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between 40 la LI 011 Onset and Death Immediate Cause (Final

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	disease or condition resulting in death)	a Ventreolar	1-10/4/W/1	0 01	5 MIN
J.	Sequentially list conditions.		corvial Ir	farch	ion ihr
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1			Date of delivery Month Day Year
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Som			1	autopsy performed? Yes 2 No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Be (25. Was case referred to medical		26. Place of Death (Check only o	ne)	
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ficate:	27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury M	28d. De work? 1 Yes 2 No	escribe how injury occ	curred
Medical Certificate: To	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)		cation (Street and Nu ty or Town, State)	mber or Rural Route Number,
Medica	(Check 2 Medical Exami	sician: To the best of my knowledge, death occured at ner: On the basis of examination and/or investigation, in se Practioner: To the best of my knowledge, death occu	my opinion, death occurred at the tim	ne, date and place, and	due to the cause(s) and manner stated.
_	29b. Signature and title of certifier	290	License number	29d Date sid	aned (Month Day Year)

State Registrar au

(Type, Print)

WILLIAM	VAN SANT.
09-08284	Please Type

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2009 347
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Vest
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1016 Arlington Avenue 4c. County of Death N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary land
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
nd show any ce.	Maryland N/A Baltimore
with the Maryland ms 23a or 28a-f show be notified at once, eral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
vith the s 23a or a notific	1016 Arlington Avenue 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
7 S BY 72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once eted by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
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5-0036 ed within 72 hour lygione other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)
-003 d withir giene. ther the E Medi	12 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21, be fill mital It riked emt, 186	Joseph B. Van Sant, Susan L. Tripp
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph B. Van Sant, Father 13850 Fast Marina Drive Unit 502 Aurora, © 80014
te lea a	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 20c. Location - City or Town, State
Baltimore, permit Pages I an Department of Hee Important: If it injury or other tr	4 Donation 5 Other Specify: Metro Crematory Inc. 10/29/09 Baltimore, Maryland
Bal permi Depa Impo injur	21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and
kaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Death Due to (or as a consequence of):
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
50, Or or or or or or or or or or or or or or	d
50, te be ex ysician burial	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 68760, e death certificate be the attending physic od for use as the burranysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
). Box 6876 the death certificat the attending ph ched for use as the Physician/IV	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
P.C.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Records, P.C The law requires that ficate has been signed to age 2 should be deta Completed by	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir rs after death. The Director: After this certificate has been sided in by the funeral director, page 2 should berrification: To Be Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other; A Nursing Home 5 Residence 6 ✓ Other: Scene
Ing Physic Ing Physic After this funeral dir	27. Manner of Death 28a. Date of Injury (Month. Day. Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Sion Attendi r death. ector: by the f	Natural 5 Pending Investigation Fd 10/25/09 Fd 12:27 pm 1 Yes 2X No unk Unk
Division c Bispital or Attending 24 hours after death. Funeral Director: Af pately filled in by the fun ral Certification	28e. Place of Injury: At home farm, street, factory, office building, etc. 4 Homicide 28e. Place of Injury: At home farm, street, factory, office building, etc. 4 Homicide 28e. Place of Injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 4 Order injury: At home farm, street, factory, office building, etc. 5 Order injury: At home farm, street, factory, office building, etc. 5 Order injury: At home farm, street, factory, office building, etc. 5 Order injury: At home farm, street, factory, office building, etc. 5 Order injury: At home farm, street, factory, office building, etc. 5 O
Division To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the edical Certificati	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the II within 24 To the F complete	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	hý h), n O.C.M.E. October 26, 2009
D	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland	•	tificate c			. No. 200	9 34717
ı	Physicia /Medic		1. Decedent's Name (First, Middle, La ELTA S					2. Date of Death Month	Day Year	
A. C.	Examin		4a. Facility Name (If not institution, give		4		n, or Location of Death		4c. County of De	ath
			FRANKLIN Squ			Ro If Under 1 Ye	sedale ar [If Under 24 Hrs.]	0.00.1(0.11		imore
	Funeral Director				39 Yrs.	Months Da		8. Date of Birth	920 MA	irthplace (State or Foreign Country) ARYLAND
	aryland show	or	Usual Residence of Decedent 10a. State	LTIMORE 10c. City,	Town or Loc		DLE RIVER			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number		_	10f. Zip Cod			. Citizen of What C	
	th with	al Di	2128 FIRETHOR	NE ROAD			21220		U.	S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Medical Examination to Inofflied at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify C	of Hispanic Origin? (Spe Cuban, Mexican, Puerto No <i>Specify</i> :	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. WHITE
Maryland 21215-0036	n 72 hou "natura edical E	Completed	15. Decedent's Ed (Specify only highest gra	J ducation ide completed)	(Give)	lent's Usual Oc kind of work do OO NOT use rei	ne during most of working		b. Kind of Busines	s/Industry
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p	be file tal Hy d othe	Be (17. Father's Name (First, Middle, Last, ELMER		10.077		18. Mother's Name			
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2	and 2 st ealth an n 27 is r ner traur	i G	19a. Informant's Name/Relationship (TIFFANY MITCHEI		19b. Mailin					, Zip Code) 21220 BALTIMORE, MI
Baltimore,	Pages 1 al nent of Hea int: if Item iry or othe		20a. Method of Disposition Disposition Comparison 2 Cremation 3 Calculated American Solution 5 Other (Special Comparison Special Comparison Spec	ce	metery, cren	sition (Name of atory or other I LL CE	place) METERY 10		BALTIMO	
Baltii	permit. F Departm importar any injur		21. Signature of Funeral Service Licel		22	. Name and Ad		CH/ROSE		NERAL HOME
	eath certificate be executed Wedgical attending physician and for use as the burial-transit	ledical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Our diom to one cause on each line. a. Sepsis S Due to (or as a consequence of the c	ence of): ence of):			n copilition y union	,	Approximate Interval Between Onset and Death
	he law requires that the death certifics is has seen signed by the attending phoge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□	Ectopic pregn Other (specify			23d. Date of o	delivery Day Year
rds, P.	w requires that is seen signed by should be detain	þ	Part II. Other significant conditions	contributing to death but not resul	ting in the ur	derlying cause	given in Part I.			to the cause of death? Probably 4 Unknown
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/Ita	Attending Physician: he r death. ector. After this certificate h setor: After this certificate h by the funeral director, p∂ge	Be (25. Was case referred to medical examiner?	Heavital			26. Place of Death			
	Physic r this ral dir	٦.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 E	R/Outpatien 28b. Time of	t 3 DUA		me 5 Residen 28d. Describe how	ce 6 Other (Sp	pecify)
0	dlng F th. : After s funera	ition	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Year)	Injury	\	Work? 1 □Yes 2 □ No	Edd. Deddilbe flori	injury occurred	
Division of	I or Attencatter death after death Director: I in by the	Certification:	3 Suicide 6 Could not be determined		ne, farm, stre	eet, factory, offi	ce	28f. Location (Stre City or Town,		Rural Route Number,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C		nysician: To the best of my know niner: On the basis of examinat and manner stated.						
	To the within To the	Me	29b. Signature and title of certifie	/ /		29c. Lic	ense number	290	d. Date signed (Mo	nth, Day, Year)
	1-0		> Melia E.	Tanchez , 1	11)	Do	1067697		10/24/0	9
	4		30. Name and address of person who	completed cause of death (Item		Print)	stern BLU	0 855 €	xmd :	21221
	Sta Registr		31. Date filed (Month, Dav. Year)	2009 32. Restrars Signate	ure	barker	-			

Please Type of Printin Black Indelible Ink 2508 yre All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 2009 9:30 P. M WITHERSPOON 26 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE 2529 LOYOLA SOUTHWAY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 12/21/1924 Birthplace (State or Foreign Country)
 SC Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** 251-16-9989 1 □ M 2 🔀 F Months Days Hours Min. 84 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show the Weddall Evantiner must be notified at 1 Yes 2 □ No BALTIMORE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21202 1708 GUILFORD AVENUE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or Specify: BLACK 1 ☐ Yes 2 🌠 No Specify ò 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOTWEAR MACHINE OPERATOR h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic ev STUKES JULIA CHARLIE WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 324 E.LANVALE ST., BALTO., MD 21202 HAROLD WITHERSPOON/SON 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 11/04/2009 BALTO., MD 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS JAMES A. MORTON & SONS F.H., 22. Name and Address of Facility 21. Si snalure of Funeral Service Licensee U. 1701 LAURENS ST., BALTO., MD 21217 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advenced metastetic gashic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, That to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed burial-transit Due to (or as a consequence of) Box 68760, physician pe Physician/Medical the as) attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.O. I ed by the a 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an N autopsy performed page this certificate 1 ☐ Yes 2·☐ No 2 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Doughtris Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit မ 27. Mann of Death

✓ Natural

2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ke Dhillen 09

State

Registrar

DHILLON 32. Registrar's Signature

A. park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONIKA 31. Date filed (Month, Day, Year)

OCT 29 2009

3333 N. Calvert St. Ste. 555

00063540

101 29/

Baltimore, Md. 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Security to the control of the property of the			State of Maryland / Department of Health a 1- For State Registrar Certificate of Death	ind Mental H	nygiene Reg. N	200	09 3471
1.1370 Cherry Hill Road Sec 1.490 (horse) Sec 1.490 (hor			1. Decedent's Name (First, Middle,Last) Marcos Octavio Catacora Andia		2. Date of Death Month Da October 21, 2	y Year 2009	
Direction Courty				or Location of Deat	h		
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one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	After thi	2	1 ✓ Yes 2 No 1 Impatient 2 Exodupation 3 DOA 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. In	1 140.0			er, ocerie
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State Registra

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29b. Signature and title of certifier

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Ling Li, MD

31. Date filed (Month, D

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Yea 2

20

Assistant Medical Examiner

32. Registrar's Signature

reun

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d, Date signed (Month, Day, Year)

October 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08100 State of Maryland / Department of Health and Mental Hygiene 2009 Camara Kouyatt Allen 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 18, 2009 Medical Examiner Camara Kouyatt 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Days Hours Months Country) NY Director Oct.26,1967 41 Yrs. 1 M 2 XF 205-62-0754 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County any Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tramarite event, the Medical Examiner must be notified at once. <u>Bowie</u> Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20716 16701 Bridge Rd.#303 Governors 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 X No Yes Specify: Black Divorced If Yes, Give Year Yes 2 X No specify: Widowed 16b. Kind of Business/Industry ecify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done

Physician 'Medical aminer

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ss (Street and Num	ber or Rural R	oute Number, C	ity or Town, State,	Zip Code)
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	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	n. Do not enter the mod	e or dying, sacri as c	dialo or roop			Between Onset and Death
	Immediate Cause (Final disease a. Hypertensive	e cardiovas	cular dis	ease			Death
	or condition resulting in death) Due to (or as a consequence of						
	b.	_					
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):					
Ë	cause. Enter Underlying Cause						
g	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	of):					
ш —	d		- 22				
Physician/Medical Examiner	X UNPENDED AMENDED 23a,27	7,perm,E g8	397 11/3/0	19 TT			
ğ	IF FEMALE: 23c. If yes, outcome of pre-	gnancy			23	3d. Date of deliver	
Ĭ.	23b. Was decedent pregnant in the past 12 months?	2 Fetal dea	th 3 Ectop	ic pregnancy		Month I	Day Year
<u>:</u>	4 Pregnant at time of d	death 5 Other (S	ipecify)				
ys	1 Yes 2 No 9 V Unknown 9 Unknown					13 4.4.	the same of death?
立	Part II. Other significant conditions contributing to death but not	resulting in the underly	ing cause given in P	Part I.			the cause of death?
Completed by					1 Yes 2	No 3Pro	bably 4 🗸 Unknown
ted					24a. Was an		utopsy findings available
음					autopsy performed?		completion of cause of
E				1		No 1 ✓ Y	es 2 No
ŭ	25. Was case referred to medical		26.Place of Death	n (Check only c	one)		
Be	examiner? Hospital:	ER/Outpatient 3	DOA Other	Nursing Hor	me 5 Resid	dence 6 Othe	er:
۵	1 Ves 2 No Impatient 2 2 27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury at Wo	rk? 28d.	Describe how in	njury occurred	
Ë.	(Month, Day, Year)	,	1 Yes 2				
aţį	2 Assistant Investigation					and Number of P	ural Route Number, City
ij	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, fac	tory, office building,	etc. 281.	or Town, State)	and Number of K	urai Route Number, Ony
Ë	4 Homicide determined (Specify)						
Ö	29a. Certifier	edge, death occurred at	the time, date and p	place, and due	to the cause(s)	and manner as sta	ted.
ca	one) 2 Medical Examiner: On the basis of examination	and/or investigation, in	my opinion, death o	occurred at the	time, date and p	place, and due to t	he cause(s)
Medical Certification: To	and manner stated.		29c. License numbe			d. Date signed (M	
Σ	29b. Signature and title of certifier			OCME		ctober 20, 200	19
	Theday WI The of IA.	me .)	O.C.M.E.				, <u> </u>
	30. Name and address of person who completed cause of death (Ite	em 23a)					

34721

1121 hrs

10d. Inside City Limits

1 X Yes 2 No

State Registrar

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

			1 - State of Maryland / Department / Department / De	artment of Health and N <i>rtificate of Death</i>	nental Hygid Red	ene 2009	34722
			Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Annelle Gunn Billington		October	14, 2009	4:25 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
~- ¹			Sunrise Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Montgomery Villa		Montgome:	ry nplace (State or Foreign
	Funeral Director		577-26-3512 1 □ M 2 🖾 F 85 Yrs.	Months Dave Hours Min	June 10,	Year) Cor	nessee
-	Ъ		Usual Residence of Decedent				10.1.1-1.1-07.11-7
	arylar show	ř	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	Maryland Montgomery Montgomer 10e. Street and Number	y Village 10f. Zip Code	100	g. Citizen of What Cou	
	with 3a or	٥	19310 Clubhouse Road #108	20886		nited Stat	
	death	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer Black, White	ican Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a literal Examinar must be rediffed at once.	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	1 □Yes 2 ☑ No Specify:	riidan, etc.,	Specify: Whi	
0500-61	"natura	Completed	(Specify only highest grade completed) 1 (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		6b. Kind of Business/I	ndustry
7 7	12 should be filed within "h and Mental Hygiene. 7 Is marked other than "traumatic event, If a Marken	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Employed	D	ress Maker	
and	be file tal Hy d othe	Be (17. Father's Name (First, Middle, Last)	1	e (First, Middle, Ma	aiden Surname)	
Z Z	ould t I Men narke natic e	은	George Nelson Gunn	Katy Lou			
	d 2 sh th and 7 is n traum		(7)	ng Address (Street and Number or Rui	·		ip Code)
<u>a</u>	tem 2		Pamela Jeanne Colbert (Daughter) 605 20a. Method of Disposition 20b. Place of Dispo			Oc. Location - City or 7	Fown, State
<u> </u>	Pages ent or nt: If I		1 Burial 2 La Cremation 3 Hemoval from State	itan Crematory 10/	15/09 A	lexandria,	Virginia
Dallimor	permit. Departm Importa any inju		21 Signature of Experies Language AA 2	2. Name and Address of Facility DeV D. East Deer Park D	ol Funer	al Home	,
Δ_	89589	î i	1000g/ 1 1 1/V+1 G	aithersburg, MD 20	8//		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
-01	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cardiomyorathy				
-	Examiner		Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly that Initiated events conditions)				
	ecuted Ind transit	Examiner	cause Unsease or muly that initiated events c. resulting in death) Last Due to (or as a consequence of):				
6/00,	iicate be executed physician and s the burial-transit	a E	resulting in death) Last Due to (or as a consequence of):				
00		edical	d		-		
XOD	n certi ending use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
ם .	e deatl he atte	sician/M	in the past 12 months? 1 Yes 2 No 1 Pregnant at time of death 5 1 Pregnant at time of deat	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
7	hat the d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e. Did toba	acco use contribute to	the cause of death?
ecords,	Physician: The law requires that the death certificate this certificate has been signed by the attending trail director, page 2 should be detached for use as	ed by	Atrial Fibrillation	and onlying database given in a later	1 □ Yes	s 2 □ No 3 □ Pr	obably 4⊠ Unknown
Leco	e law re has ber ie 2 sho	Completed			24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
70	n: Th fficate nr, pag		25. Was case referred to medical	00 81 48	1 □ Yes 2	XNo 1 □Yes	2 🗆 No
NI S	/sicia s certi	o Be	examiner? 1 Yes 2XNo Hospital: 1 Inpatient 2 ER/Outpatie	Other:	th <i>(Check only one</i>	nce 6⊠Other <i>(Spe</i>	Assisted
	ding Physician: The lav h. After this certificate has funeral director, page 2	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		511)/ 112 V 2212
000	Attending r death. ector: Afte by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION	l or Attendi after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2□ Medical Examiner: On the basis of examination and/or in and manner stated.				
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	h, Day, Year)
	20		Jay B Willen ms	D 55258		October 15	, 2009
	•		30. Name and address of person who completed cause of death (Item 23a) (Type,		D 20017		
	Sta	te	Gary B. Wilks, M.D., 6430 Rockledge D 31. Date filed (Month, Day, Year) 32. Registrar's Signature		D 2001/		
	Registr		31. Date filed (Month, Day, Year) OCT 16 2009 32. Registrar's Signature	Mad.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#19aperINF, 10-22-09, BM, McCo Certificate of Death 34723 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 12:40 am Halina Berovetz 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montaomeru 13124 Buccaneer Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country Ukraine May 22. 1 🗆 M 2 🗓 F Months Hours 099-28-5486 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛛 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 U.S.A. 13124 Buccaneer Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Library of Congress other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. Afanasii Petrowski Elena Sachkowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Myroslava Semerey</u> 13124 Buccaneer Rd., Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of Stempler, semator) glother glaced St. And tell will train an Orthodox Cemetery 20c. Location - City or Town, State South Boundbrook, 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State 10/16/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinalli Funeral Home, Inc. of Funeral 21. Signa re 11800 New Hampshire Ave., Silver Spring, MD20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Years Immediate Cause (Final Physician/ Metastatic Liver Adeno Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a gonsequence of: attending physician and for use as the burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Other (specify) Month Year Pregnant at time of death Day signed by the a d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 performed? Yes 2 X No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 🕮 Residence 6 🗆 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 X Natural injury 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director. / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) Mn October 15, 2009 D0050612

Registrar

DHMH 17 Rev 7/2009

State

Leisure World Blvd. Silver Spring.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3305 N.

<u>Samuel Mal</u>ler.

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Casper E.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of treath (Item 23a) (Type, Print)

M.D.

32. Registra s Signature

Cl'ine.

D16428

300 West Ninth Street, Frederick, Maryland 21701

Please Type or Print in Black indensity with and Mental Hygiene 2009 amend #3/25-28f Marylland Peparting 100 Health and Mental Hygiene 2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar Amended#29d perMD FCHD, KS 10/14/10/20ate of Death 2. Date of Death Dav Month Year

Physician /Medical Examiner

attending physician for use as the burial P.O. Box 68760 icate has been signed by ; page 2 should be detach Records, of Vital After this certification, Division

Bates, Dale

1. Decedent's Name (First, Middle, Last) \mathbf{P}^{M} DALE ARDEN BATES OCTOBER 9 2009 8:44 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 17 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 2 M 2 □ F AR Director JULY 1935 432-58-5825 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, If we Medical Examinat must be notified at 1 Yes 2 □ No MONTGOMERY POOLESVILLE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 17404 HUGHES ROAD 20837 Funeral 12. Was Decedent Ever 1954. Armed Forces? 1 1949 2 1 No 1960 If Yes, Give Year or Dates: 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1□Yes 2⊡No Specify WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING ELECTRICAL ENGINEER 18. Mother's Name (First, Middle, Maiden Surgeme) 17. Father's Name (First, Middle, Last) Be JESSE EUGENE BATES ELIZABETH FRANCES MENKE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17404 HUGHES ROAD, POOLESVILLE, MD 20837 ZANNIE BATES / SPOUSE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State STAUFFER CREMATORY 10/13/09 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final age **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Vear 5 ☐ Other (specify) 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier ជ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier 66264 October 9,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

BABAK PIROUZ, MD

31. Date filed (Month, Day, Year)

32. Registra s Signature

4 2009 ▶

8600 OLD GEORGETOWN RD., BETHESDA, MD 20814

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9, Charles Wilson Becker October 2009 1327 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year Oct 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 213-38-5037 69 1939 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ust be notified at 1 XYes 2 □ No Maryland Carroll Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Hayride Lane 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after dec Department of Health and Mental Hygiene. Interpretate if the 27 is marked other than "natural", or items any injury or other traumatic event, the Wedfort Exp. it is any once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Auto Body 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Wilson Becker Thelma Sell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita E. Becker, wife 3 Hayride Lane, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Lutheran Cem 10/13/2009 Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 سكميه 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 10/9/09 **Physician** disease or condition resulting in death) serb /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Divisito (or as a nunsequende of) or Attending Physician: The law requires that the death certificate be executed - Sma Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Tyes 2 No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ŪNO 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | UH0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending regarding A hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WESTMIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICE ROBERT LENTER

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 13

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Dark

32. Pégistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 1 9 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/11/2009 1720 М CHRISTOPHER A. BARKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Ye 6/28/1981 Hours Min 1 🙀 M 2 🗆 F **Director** Yrs. WASHINGTON, DC 216-19-4289 28 Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MARYLAND PRINCE GEORGE'S BRANDYWINE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13612 CHESTNUT OAK LANE 20613 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced Specify:BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WINSTON ALLAN BARKER SR CHRISTINE TRAPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHESTNUT OAK LANE BRANDYWINE, MD 20613 CHRISTINE A. BARKER / MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/16/2009 CLINTON. MARYLAND RESURRECTION 21. Signature of Funeral Service License 22. Name and Address of FacilityPOPE FUNERAL HOMES, P.A. Part 1. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. 538 MARLBORO PIKE FORESTVILLE, MARYLAND 20747 23a, Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner moni Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed en attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Completed Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Tyes Yes å 25. Was case referred 26. Place of Death (Check only one) Other: No မ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred

P.O. Box 68760 Records, of Vital

on	eath. or: Af he fui	tifica	2 Accident	Investigation	(, = 4),	M	1 🗌 Yes 2 🗆 N	10			
Divisi	tal or Att	al Certi	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		ory, office		(Street and Number own, State)	or Rural Route Numbe	er,
	he Hospi in 24 hou he Funer pleted fill	Medica		Medical Examine	ian: To the best of my know r: On the basis of examinatio Practioner: To the best of m	n and/or investigation, in	n my opinion, death occ	urred at the time, date	and place, and due to	o the cause(s) and mar	nner stated.
	To the within To the comp		29b. Signature and t	title of certifier	LMD	29	D 25 7	53	29d. Date signed (Month, Day, Year)	
R	4		James	An drow	poleted cause of death (Item	7503 S	veratts	Road, (Windon.	mD 204	35
	Sta Registr		31. Date filed (Month	C DAILING	32. Registrar's Signa	ture .	,		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 34728

			1- For State Registrar	Certi	ificate of D	eath		Re:	g. No.	04720
	/sicia	an/	Decedent's Name (First, Middle,Last)	D		-		Date of Death Month	Day Year	3. Time of Death 0927 hrs
edical Ex	Kami	ner	William Le 4a. Facility Name (if not institution, give street		rian 14b	City Town or	Location of Death	October 12	2, 2009 4c. County of Death	0327 1113
			1256 Booker Terrace			Seat Pleasa			Prince George	's
Fun			Social Security Number 6. Sex	7. Age (In yrs. las		f Under 1 Yea		_	h(MM/DD/YYYY) 9. Birt Foreigi	2
Dire	ctor		231-31-3166 1 ₃ M 2	_ _F 25	Yrs.	Months Day	s Hours Min	March	13, 1984 co	intry) D.C.
	γι		Usual Residence of Decedent 10a. State 10b. County	10c City To	own or Location			_		10d. Inside City Limits
P	LC.		MD Prince Georg		oitol He	ights				1X Yes 2 No
arylan	8a-fs	Director	10e. Street and Number		1	Of. Zip Code		10	g. Citizen of What Coun	try?
the M	23a or 28a-f show any notified at once.		1256 Booker Terrace			20	743		U.S.	
h with	be no	Funeral		as Decedent Ever in U.S. med Forces?			spanic Origin? (S n, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
er deal	or it		3 Widowed 4 Divorced If Yes, G	Yes 2 No	1 V	es 2 x No	snecify:		African	-American
urs aft	'mine	d b	15. Decedent's Education (Specify only higher		I6a. Decedent's	Usual Occupa	tion (Give kind of		16b. Kind of Business/li	ndustry
5 72 ho	al Ex	Completed		lege (1-4 or 5+)	•	_	DO NOT use ret	-	Food Serv	d an
003 within iene.	Media	티	12		гооц па		Specialia			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene.	ed oth	S S	17. Father's Name (First, Middle, Last) Richard Tucker				18.Mother's Name	e (First, Middle, M Berrian		
212 ould be	mark ic even	70 E	19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailing A	ddress (Stree	et and Number or	Rural Route Num	ber, City or Town, State,	Zip Code)
MD d 2 sh lth and	n 27 is iumat		Leroy Johnson-Uncle						n, MD 20735	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	If iter		20a. Method of Disposition 1 Burial 2 X Cremation 3 Rem	oval from State cre	ace of Dispositio ematory or other	place)		Date	20c. Location - City or Riverdale,	
timent Page	rtant:		4 Donation 5 Other Specify:		verdale			-19-09		
Bal permi Depar	og ili		21. Signature of Funeral Service Licensee	James Linco	oln Bon	nette 8	& ASSOC.	Funeral	504 28th St Home 2	., N.E WDC 0018
Physic	cian		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused the death. D	Do not enter the i	node of dying,	such as cardiac	or respiratory arre		Approximate Interval Between Onset and
/Med Exam		1	Immediate Cause (Final disease a Conta	ct Gunshot Wound	of Head					Death
<i>S</i> .			or condition resulting in death) Due to (or as a consequence of);						
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ecuted	physician and the burial - transit		d							
Records, P.O. Box 68760, The law requires that the death certificate be executed	sician ourial	edical	UNPENDED AMEN	IDED						
876 tificate	ng phy as the l	ξ	23b. Was decedent pregnant in the	If yes, outcome of pregna Live birth	ancy 2 Fetal	death 3	Ectopic pregn	ancy	23d. Date of delivery Month	ay Year
Box 68760, edeath certificate by	attendi or use	sicia	past 12 months?	Pregnant at time of deat	_	(Specify)			20	0
the de	this certificate has been signed by the attending I director, page 2 should be detached for use as	Physician	Part II. Other significant conditions contrib	Unknown uting to death but not res	ulting in the und	erlying cause g	given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death.	signed be deta	d by			_			1 Yes	2 No 3 Prob	ably 4 Unknown
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eco he law	ate has	dmo			•			perform 1 ✓ Yes 2	med? death?	
14 .	ctor, p	BeC	25. Was case referred to medical examiner?		.	26.Place	e of Death (Check	only one)		
f Vit	r this c	To	1 Yes 2 No	i iiipatieit Z L	R/Outpatient 3		Other Nursi		Residence 6 🗹 Other	Scene
□ O o	: After e funeral	ion:	1 Natural 5 Pending FC	(Month Day,Year) DUND:	28b. Time of Inju FOUND:	´ l`	Yes 2 ✔ No	Subject shot		
'iSiO ' Atter er dear	irector by th	ficat	2 Accident Investigation O	ct 12, 2009(e. Place of Injury - At hon	0909 hrs ne, farm, street, f	actory, office t	building, etc.		treet and Number or Ru	ral Route Number, City
Div ours aft	illed i	Certification:		pecify) Single Fami	ly			or Town, St 1256 Booker T	tate) Ferrace, Seat Pleasar	nt, MD
Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the							
To th withir	To th	Medical		anner stated.	aron investigation	29c. Licens		a. the time, date t	29d. Date signed (Moi	
		_	(m)			O.C.			October 13, 2009	
10 A			30. Name and address of person who complete	ed cause of death (Item 2	?3a)	J				
12 2				ant Medical Exami		enn Street	, Baltimore, N	/ID 21201		
		tate trar		32. Registrar's Signature	add					

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nomas E Combs		State of Maryland	/ Depai	rtment o <i>tificate o</i>	t Health <i>t Death</i>	and Ment	aı Hygie		200	19 3472
D	R	egistrar 1. Decedent's Name (First, Middle,Last)	Cert		Death		2. Da	Reg. ate of Death	NO.	3. Time of Death
Physician ledical Examine	4	THOMAS E. COMBS					Se	onth Deptember 2	24, 2009	2112 hrs
	4	4a. Facility Name (if not institution, give street and number) 114 Daniel Bathon Drive			4b. City, To	wn, or Location of			4c. County of Death Cecil	
Funeral	Ę	5. Social Security Number 6. Sex 7. Ag	e (In yrs. Ia	st birthday)	If Under		Min.		MM/DD/YYYY) 9. Birti Foreigi	n
Director		221-54-7357 1XM 2 F	47	Yr		Lays	()2/27/1	1962	DE
any		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Loca	ation					10d. Inside City Limits
		MD CECIL	ELE	CTON						1 Yes 2 X No
faryland 28a-f show	Ulrector	10e. Street and Number			10f. Zip C	Code		10g	. Citizen of What Cour	ntry?
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death with the Maryland or Items 23a or 28a-f sho must be norified at onc.	あ ロ	11. Marital Status 1 Never Married 2 Married Armed Forces	?			Cuban, Mexican,			White, etc.	J
ter dez		3 Widowed 4 X Divorced If Yes, Give Year or Dates:	X No	1		No specify:				ITE
hours after "natural", Examiner		15. Decedent's Education (Specify only highest grade co		16a. Decede during	ent's Usual C most of work	occupation (Give ling life. DO NOT	kind of work use retired)	done	16b. Kind of Business/	Industry
36 thin 72 h te. than "n edial E	plet	Elementary/Secondary (0-12) College (1-4 or 12	5+)	WELDI	R/FAR	RICATOR		,	FABRICATI	ON
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215 be file ntal H rked o	8	CHESTER COMBS				FRA	NCES_	WILLIA	MS State	Zin Code)
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she unative event, the Medical Examiner must be notified at one.	_	19a. Informant's Name/Relationship (Type, Print)				L DR DOV			er, City or Town, State	, 2ip code)
	ŀ	AMANDA L. CULLEN/DAUGHTER 20a. Method of Disposition	20b.	Place of Disp	osition (Nam	e of cemetery.		ate 1990	20c. Location - City or	Town, State
TOFE ages 1 at of H t; If ii	-	1 Burial 2 X Cremation 3 Removal from S	MAY	crematory or ERDALE	other place) CREM	ATORY	10/1	/2009	NEWARK, D	Е
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite Important: If ite Imjury or other tr	+	4 Donatton 5 Other Specify: 21. Signature of Funeral Service Licensee		22	Name and	Address of Facilit	у кн			
pe gg		28á. Part.l. Enter the disease, or complications that cause	1.11 1.11	110	100 N	DIIPONT P	KY NE	CAST	LE. DE 197	Approximate Interval
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be excurbing 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medio	IF FEMALE: 23c. If yes, outc							23d. Date of delive	
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COFC law re has be	Completed							autop perfor	med? death?	
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Vital hysician this centricated	To Be	examiner?	atient 2	ER/Outpat	ient 3 🔲 [OOA Other 4			Residence 6 Oth	ner: Scene
of ing Ph	n: T	27. Manner of Death 28a. Date of (Month, Da	njury ly,Year)	28b. Time	of Injury	28c. Injury at Wo		8d. Describe I nk	how injury occurred	
Sion Vitend death. ector:	catio	Fending Fd 9/2	4/09	Fd 8:	18 pm	y, office building,	etc. 2	8f, Location (Street and Number or	Rural Route Number, City iel Bathon D
Divis	Certification:			way ir]	E1kton	, MD	iel Bathon D
Division of Vital Records, To the Hospiral or Attending Physician: The law requirent the Law requirent to the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	ಹ	29a. Certifier	f my knowle	edge, death o	ccurred at th	e time, date and	place, and d	ue to the caus	se(s) and manner as s	tated.
To the within To the comple	edical	one) 2 Medical Examiner:On the basis of each and manner state	examination ed.	and/or inves		oc. License number		me time, date	29d. Date signed (/	
	Ž	29b. Signature and title of certifier			28	O.C.M.E.			September 25	
		30. None and address of person who completed cause	of death (Ite	em 23a)				_		
		Melissa Brassell, MD Assistant Medi	cal Exam	niner 11		treet, Baltimo	ore, MD 2	1201		
	ate	31. Date filed (Month, Day Year) 32. Regi	strar's Sign	atur	1					
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician William 0557 2007 lay 10 -/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kockville Adventist Hosp Montgomery Co. rove If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 247-34-9590 1 X M 2 □ F Director 16-16-1927 Usual Residence of Decedent purmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Innportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Ever, increase the marked of the page. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Washington **Funeral Director** DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Roxanna Rd 20012 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\text{No} \) No 1 \(\text{1.5} \) Year or Dates: \(\text{4} - \text{1} - \text{53} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be harlot မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9702 Cottvell Terrace Silver Spring md 20903 Sr. ders, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Quantico Nat Cem: 10-20-2001 Iriangle VA. 4 ☐ Donation 5 ☐ Other (Specify) 799# 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 814 LIPSKUTST. NW. TRI-State Funeral Services anu E · (e) rela WDC 20011 Approximate Interval Between Onset and Death 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neumonia 10 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 □No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. within 24 hours after death

To the Funeral Director:
completely filled in by the f

Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enahi ralle 31. Date filed (Month, Day, Year) State 2009 16 Registrar

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29a. Certifier

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Marial Purising	importance or regard and western and western strong the manual control of the manual con	a
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Funeral Director

		For State Registrar		State of M	iaryiani	Ce.	rtificate of	Death	ieniai ny	Reg. N	200	9 34731
Physicia /Medic		1. Decedent's Nam	11.	e, Last) N THOMAS CA	MPBEL:	L			2. Date of Do Month OCT	D	ay Year 0 9	3. Time of Death 1:00 A M
Examin		4a. Facility Name (, give street and number			4b. City, Town, o	or Location of Death		4	c. County of Dea	ath
				AVAL MEDICA				BETHESDA	- D - (D)			rgomery
Funeral Director		5. Social Security NN/A		6, Sex 7. A 1 M 2 □ F	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of Bi (Month, D Oct 8,	ay. Year	r) C	rthplace (State or Foreign Country) ryland
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f sho	ξ	MD	Freder	ick	Fred	erick						1 XYes 2 ☐ No
r 28a	Director	10e. Street and Nu	mber				10f. Zip Code			10g. C	itizen of What C	country?
23a o		9662 Fle	etwood	Court			21701			USA		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show way hurry or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 XNever Marr 3 Widowed		12. Was Decedent Armed Forces ied 1 □ Yes 2 ☒ If Yes, Give Year or Dates:	? No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spe lan, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi Specify: W	ite, etc.
lical	eted	(Spec	15. Decedent	t's Education st grade completed)		16a. Dece	dent's Usual Occup	pation during most of worki	ina	16b.	Kind of Busines	s/Industry
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ntal F ed ot ever	Be	17. Father's Name		Campbell				Louella !				
nark mark matic	은	19a. Informant's N				19h Maili	na Address (Street	t and Number or Rura				Zin Code)
Ith an 27 is 1				bell/mother				od Court				
nt of Hea : If Item ? · or other		20a. Method of Dis	position Cremation	3 ☐ Removal from State	20b. P	lace of Dispo emetery, cre	osition (Name of matory or other pla	ice)	Date	20c.	Location - City o	r Town, State
urtme ortant njury		4 ☐ Donation 21. Signature of Fi			FIL			matory 10		<u> </u>	odbine,	
impo any l		Beve	ily f	Helite		251 B€	everly L.		e, P.A.	. Cl		le, MD 21029
ysician /ledical		23a. Part1. Enter to shock, or head immediate Cause disease or condition resulting in death)	art failure. List (Final on	complications that cause only one cause on each a. PREM	line. IATURI	TY	ter the mode of dy	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
aminer	Je.	Sequentially list co	nditions,	b								
unsit	Examiner	Cause (Disease or	injury	500.10 (51.10								
physician and the burial-transit		that initiated events resulting in death)	s Last	cDue to (or a	s a consequ	uence of):						
hysici he bu	edical			d								
ing p		IF FEMALE:		T						-		
Wintin 24 nouts after death. Wintin 24 nous after death. Wintin 24 nous after death. After this certificate has been signed by the attenting p. completely filled in by the funeral director, page 2 should be detached for use as	hysician/M	23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknowr	months? □No	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date of d Month	lelivery Day Year
ned b e deta	by Pi	Part II. Other signi	ficant condition	ons contributing to death	but not resu	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco	o use contribute	to the cause of death?
en sig uld blu									10]Yes	2 No 3 □	Probably 4 🗍 Unknown
ate has bee	Completed									opsy form <u>ed</u> ?	prior to death	autopsy findings available o completion of cause of ?
ertific ctor, I	Be C	25. Was case referexaminer?	rred to medical					26. Place of Deat				
his co	T _O	1 Yes 2 ∑	ζNo	Hospital: 1 X Inpa	tient 2 🗆		INT 3 LI DOA	her: 4 Nursing Ho	ome 5 ☐ Re	sidence	6 ☐ Other (S)	pecify)
atn. rr: After t ne funera		27. Manner of Dea 1 D Natural 2 Accident	5 ☐ Pendin investig	gation		28b. Time o Injury	Wo		28d. Describe	e how in	jury occurred	
s arrer de I l Directo ed in by tl	Certification:	3 ☐ Suicide 4 ☐ Homicide	6	ined 28e. Place of II	njury - At ho etc. <i>(Specif</i>)	ome, farm, st y)	reet, factory, office		28f. Location City or To			Rural Route Number,
ie Funera	Medical (29a. Certifier (Check only one)		ng Physician: To the bes Examiner: On the basis and manners	of examina							
To th COTE	Me	29b. Signature and	title of certifier		son.	MD		se number .237198 (V.	A)	29d. [Date signed (Mo	nth, Day, Year)
				who completed cause of	death (Item	1 23a) (Type			L NAVA		EDICAL C	
Sta Registr		KERRY 31. Date filed (Mor	A. HUDS ith, Day, Year) 162	ON LCDR M	IC US strar's Signa		Ked	DETUESD	עוז אין	0003	, 5000	
				- 4.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) LUKE ROBERT CAMPBELL Por State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34732 2. Date of Death Month Day Year OCT 9 2009 2:30 A M

If Under 1 Year

Days

Months

7. Age (In yrs. last birthday)

Yrs

0

4b. City, Town, or Location of Death

BETHESDA

Hours

If Under 24 Hrs.

1^{Min.}

4c. County of Death

8. Date of Birth (Month, Day, Year) Oct 9, 2009

MONTGOMERY

Birthplace (State or Foreign Country)
 Maryland

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

5. Social Security Number

N/A

NATIONAL NAVAL MEDICAL CENTER

1**X**) M 2□ F

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be natified at anones.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Usual Residence of	Decedent							
	10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
ţċ	MD	Frederic	k	Freder	ick				1 XYes 2 No
rec	10e. Street and Nur			TICACI	10f, Zip Code		100	. Citizen of What Co	nuntry?
a Di	9662 Flee		urt		21701		US		Suntry:
uner	11. Marital Status		12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Spe- ban, Mexican, Puerto F	cify Yes or No-	14. Race - Am Black, Whit	
Completed by Funeral Director	1 Never Marri 3 Widowed	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 □Yes 2 No		,,	Specify: Wh	
eted	-	15. Decedent's Ed	ucation	16a.	Decedent's Usual Occi	pation	16	b. Kind of Business	
mple	Elementary/Seco	ify only highest grandary (0-12)	College (1-4or 5		life. DO NOT use retir	e during most of workin red)		1-	
ပိ	0			Ne	ver worked			/A	
To Be	17. Father's Name (Matthew I		mpbell			18. Mother's Name Louella T		,	
	19a. Informant's Na	me/Relationship (7	ype. Print)	19b	. Mailing Address (Stree	at and Number or Rura	l Route Number, C	City or Town, State,	Zip Code)
	Louella 7	Campbe	ll/mother	96	62 Fleetwoo	d Court Fr	ederick,	MD 21701	
	20a. Method of Disp		Removal from State	20b. Place of cemeter	Disposition (Name of ry, crematory or other pl	ace) Da	ate 20	c. Location - City or	Town, State
		5 ☐ Other (Specify		Final	Journey Cre			oodbine,	
	21. Signature of Fu	neral Service Licen	see /		GOING HOME	e Cremation	Service	P.O. Bo	x 784
	Her	ely I to	telle	MO125	1Beverly L.	<u>Heckrotte</u>	P.A. C	larksvill	e, MD 21029
	snock, or nea	n railure. List only o	lications that caused one cause on each lin	the death. Do r le.	not enter the mode of dy	ring, such as cardiac or	r respiratory arrest	1	Approximate Interval Between Onset and Death
	Immediate Cause (disease or conditio resulting in death)	Final n	a. PR	EMATURI	TY				Onset and Death
	3		Due to (or as a	a consequence of	of):				
er	Sequentially list cor if any, leading to im- cause. Enter Under	nditions, mediate	b. Due to (or as a	a consequence of	of):				
mir	cause. Enter Under Cause (Disease of that initiated events	lying injury	0	·					
Ex	resulting in death) L	ast	Due to (or as a	a consequence of	of):				
dical			d						
/Me	IF FEMALE:		220 If you guttage a						
cian	23b. Was decedent in the past 12	months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death				23d. Date of de Month	livery Dav Year
ysi	1 □ Yes 2 □ 9 □ Unknown	No	9 Unknown	time or death	5 ☐ Other (specify)				
y PI	Part II. Other signif	cant conditions co	entributing to death bu	it not resulting in	the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
ompleted by Physician/Medical Examiner							1 ☐ Yes	2 X No 3 □ F	robably 4 🗋 Unknown
uple							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Sol							performed 1 □ Yes 2 X	d? death?	s 2 No
Be	25. Was case referr examiner?	<u>}</u>	Hospital:			26. Place of Death			
은	1 Yes 2	40	1 X Inpatie		tpatient 3 DOA			e 6 ☐ Other (Spe	ecify)
ation	27. Manner of Death 1 Matural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injur (Month, Day	y 28b. 1 (<i>Year</i>) I	ime of 28c. Injury M 1 [uryat 2. ork? ⊒Yes 2.⊒No	8d. Describe how	injury occurred	
ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	m, street, factory, office	2	28f. Location (Stree City or Town, S		ural Route Number,
Medical Certification: To	29a. Certifier (Check only one)	1X Certifying Phy 2☐ Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination an	, death occurred at the d/or investigation, in my	time, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manner a and place, and du	is stated. e to the cause(s)
Me	29b. Signature and	itle of certifier			29c. Licer	nse number	29d	Date signed (Mon	th, Day, Year)
	*Kens	ru an	n Hind	Aon. I	010	1237198 (VA	4) (4	CT-12	-2009
t	30. Name and addre	ess of person who c	ompleted cause of de	eath (Item 23a) (Type, Print)	NATIONAL	NAVAL ME		NTER

State Registrar KERRY A.

HUDSON

LCDR

MC

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHAREKIICH Month C Physician/ -LAYTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City Health & Rehab Ellicott City Howard 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 😿 M 2 🗆 F Months Mar 1934, Year 928 NJ 81 **Director** 216-24-2897 Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 USA 3105 Brookmeade Road Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant, If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' 1 X Yes 2 If Yes, Give Completed by Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates. 1952-54 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Real Estate Title Researcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francis Julia Krause Sigmund Kajetan Charewich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Tippett (Executor) 649 Weller Drive Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Marriottsville, MD Crestlawn Mem. Gardens 10/14/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ANTGATATONERALY HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 Huxt 2 M00764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions if erry leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗋 Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? 2 1 No 25. Was case referred to medical Certificate: To Be 26. Place of Death Check only one) 2 No 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier OCT, 112009 EH, 20 WJL 3

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO8-4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#16aper FH State of Maryland / Department of Health and Mental Hygiene State Registrar AACO HEALTH DEPT. 10/14/09 cmh Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Richite Allen Chase October 2009 12:40PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2000 Forest Dr. Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ja.n 12 Birthplace (State or Foreign Country) Months Days Hours 1**X** M 2□ F 219-01-8841 91 Ĩ918 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Maryland Anne Arundel Annapolis 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Forest Dr. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1950 – 51 1 ☐ Never Married 3 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

Supply Supervisor United States Elementary/Secondary (0-12) College (1-4or 5+) 12th6yrs Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvin Chase Helen Diggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matilda Chase(Wife) 2000 Forest Dr. Annapolis, Md. 21401 20a. Method of Disposition Date 20c. Location - City or Town, State 20bt Place of Disposition (Name of cemetery crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 10-14-09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Manual Research of Sacil Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. Dec Mc0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performe 1 ∐Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

certificate be executed

P.O. Box 68760,

Division of Vital Records,

ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t

To the I within 2 To the I

completely filled in by the

Medical

State Registrar

Physician

Examiner

Funeral

Director

show

r than "natural", or items 23a or 28a-f sho

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 220 mote. Once.

Director

Funeral

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Completed

Be

2

the Maryland

/Medical

Examine and burial-tran attending physician for use as the buria Physician/Medical ned by the a signed to \$ page 2 should Completed been certificate director, Be Certification: To After this funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deat

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? Injury

Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 28d. Describe how injury occurred

2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 □Yes 2 □No

29d. Date signed (Month, Day, Year)

MD

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ph-lyn 139 010 MO

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:56 A M OCT. TUAN DAO 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Director 578-06-6260 27 3, INDONESIA 1982 JAN. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Y☐Yes 2☐No Director PRINCE GEORGES ADELPHI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9102 ADELPHI RD. 20783 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No 2 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 'natural", ASIAN Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED NURSING ASSISTANT HEALTH CARE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ THAN DAO THAO NGUYEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONEKHAM PHOMMYTHONG/WIFE 9102 ADELPHI RD., ADELPHI, MD. 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 10-17-2009 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22 CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE PANCREATITIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any leading to him edich cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuence of: executed physician and the burlal-trans SEPSIS Due to (or as a consequence of): P.O. Box 68760. or Attending Physiclan: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, SYSTEMIC LUPUS ERYTHEMATOSUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a. Was an autopsy Vital 1 ☐ Yes 2 ☐ No RESPIRATORY FAILURE 1 ☐ Yes 2**X**□No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and tite of certifier 29c. License number 29d. Date signed (Month, Day, Year) D68150 OCT. 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEJ B SIRAJ 1500 FOREST GLEN RD., SILVER SPRING, MD. 20910 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 34736 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 13, 2009 10:48A M Albert Merritt Van Doorn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chevy Chase Montgomery 8611 Woodbrook Lane 8. Date of Birth (Month, Day, Year)
Oct 27, 1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours California 1 X M 2 □ F 578-34-5634 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic every "..." 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20815 8611 Woodbrook Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1951–52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: White ģ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 4 Purchasing Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Egbert Van Doorn Melvina Rushmore 2 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8611 Woodbrook Lane Chevy Chase, MD 20815 Renee Van Doorn/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Final Journey Crematory 10/16/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician UNG amcer disease or condition resulting in death) /Medical Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter order, this Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ed by tl detach signed b Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy
performed?

1 Yes 2 2 No certificate Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Attending 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospitai or 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ATTHEW 31. Date filed (Month Day State Registrar

State of Maryland / Department of Health and Mental Hygienes a co

			1 - State Registrar		$C\epsilon$	ertificate of	Death	wentai n	Reg. No.	2009	34737
	Physic	ian	1. Decedent's Name (First, Middle, La	est)				2. Date of D	eath		3. Time of Death
13	/Med		James H. Derri	ick				Octobe	n 11	^{Year} 2009	
	Exam		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town,	or Location of Death			County of Death	3:15a ^M
-			10012 Pebble Beac	h Terrace		Tian	nsville				
	Funera		5. Social Security Number 6. S	Sex / 7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth .	9. Birth	erick place (State or Foreign intry)
	Directo		115-40-2302	19 M 2 □ F	Yrs.	Months Days	Hours Min.	Feb. 2		49 New	York
	and w		Usual Residence of Decedent 10a. State 10b. County					100. 2	1, 1,	TO ITCW	TOIR
	aryla sho	1	10a. State 10b. County	1	0c. City, Town or Lo	ocation					10d. Inside City Limits
	he M	Director	New York Orange		Walden						1 ☐Yes 2 No
	vith t	ä	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	s 23	ra	25 Derrick Lane			12	2586		Uni	ted Sta	tes
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, Its Modical Event from that be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	0- 1-	4. Race - Ameri	can Indian,
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an	d be anntal	Be	·				18. Mother's Nam	e (First, Middle	, Maiden S	lurname)	
Ξ	d Me mark matic	ျ	Robert S. Derri					Brenna			
Z Za	d2s than 7 Is I		19a. Informant's Name/Relationship (7				t and Number or Ru	ral Route Numb	er, City or	Town, State, Zij	OCODE) 07043
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ةِ	it of it of or o		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crer	sition (<i>Nam</i> e of " natory or other plac	ce) Octo	Date	20c. Loca	ation - City or To	own, State
뱵	t. Pa tmer tant:		4 ☐ Donation 5 ☐ Other (Specify		Stauffer	Cremator	v 13.		Frede	rick. M	laryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, trainforced Evantic must be notified at once.		21. Signature of Funeral Service Licens	see	22	2. Name and Addre				1 Homes	
	e o		- XUX	to	16	521 Oposs	umtown Pi	ke Fre	deric	k, Marv	land 21702
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Mali	C C						Onset and Death
	/Medical	i	resulting in death)	Due to (or as a qu	onsequence of):	+					
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	Po #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	ensequence of):				_		
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30,	oe ex	<u> </u>	resulting in death) Last	Due to (or as a co	nsequence of):						
68760,	leath certificate be executed attending physician and for use as the burial-transit	Medical	•	d							
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Вох			23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pour 1 Live birth 2 Live		Ectopic pregnancy	.,		230	d. Date of delive	ery
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Э.	w requires that the dispersion is been signed by the should be detached	된	9 Unknown								
Ś	res the		Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
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Vital	ician: Th certificate ector, pag		25. Was case referred to medical examiner?				26. Place of Death		2 X No	1 ☐ Yes	2 🖾 No
of V	Physician: This certificatal director, p		1 Yes 2 No	lospital:	2 ER/Outpatient	3 DOA Othe				704 (0	Brother's Residence
		Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time of	28c. Injury Work	/at 2	28d. Describe h			Residence
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Division	I or Attendl after death. Director: A d in by the fu	<u>≅</u>	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury -	At home, farm, stre	et, factory, office	2	28f. Location (S	treet and N	lumber or Rural	Route Number
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	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my	knowledge, death	occurred at the tim	ne, date and place, a	and due to the o	cause(s) ar	nd manner as st	ated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) A Medical Examil	ner: On the basis of examend manner stated	mination and/or inv	estigation, in my op	pinion, death occurre	ed at the time, o	date and pla	ace, and due to	the cause(s)
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	6	3	0. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, P		•		1	_ / - /	
	<u> </u>	_ [_	Susan Kesmodel MD				moro Me-	err1 1	2120	1	
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	Registra	r	00114	: 2009 Dens	un B.	Manka!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34738 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:30 P M 2009 R. Dehart October John Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Cooks | Hours | Min. | 0ctober 5, Frederick Northampton Manor 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Country) Maryland Months 1√M 2□ F 217-36-8802 73 Vrs 1936 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I's Medical Examina must be mailled at Frederick Maryland Frederick 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21704 USA 3535 Urbana Pike Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married white 1 ∏Yes 2X XNo Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable McCormick John R. Dehart, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Cynthia Dehart - wife 3535 Urbana Pike, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Frederick, Maryland Stauffer Crematory 10/11/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) John **Physician** /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending ph for use as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached signed by the detacher 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera 1 Natural 5 ☐ Pending investigation 1 🗆 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

Box 68760, P.O. Records, Division of Vital requires that the death certificate be executed

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To the Hospital

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within 72 hours after death

2 should be filed within 7 hand Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

mpleted cause of death (Item 23a) (Type, Print) tame and address of person who N.D Bollar Trabun 31. Date filed (Month, Day,

29b. Signature and title of certifie

196 Thunas

29c License number

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	tate of Maryland	d / Dep Ce	artment of I rtificate of I	Health and I Death	Mental Hyg	leg. No.	09	34739
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ļ	Funeral Director		5. Social Security Number 6. Sex 1 \(\frac{1}{X} \) M	2 □ F 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 01/29/1		9. Birthp Count	lace (State or Foreign ry) KY
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9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fi	1 Never Married 2 Married	Armed Forces? Ves 2 Ne7-67 Ves, Give 47-67 /ear or Dates.	, 13.	If Yes, specify Cub.	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Bla	e - America ck, White, e Whit	tc.
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and	be filed v ental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Joseph Dixon	,			18. Mother's Nam Florida	ne (First, Middle, M Morgan	Aaiden Surnam	e)	
Mary	d 2 should alth and M n 27 is ma er trauma!		19a. Informant's Name/Relationship (Type, P Maria Dixon Spot		19b. Maili 89 5	ng Address (Street Autumn Va	and Number or Rur alley Land	al Route Number, e Gambri	City or Town, S	State, Zip C 21054	ode)
Baltimore, Maryland 21215-0036	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 □ Burial 2 XXX remation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State Ce	metery, crei	osition (Name of matory or other pla Cremator	ce)		20c. Location Glen	- City or Tov Burni	•
Balti	permit. Departr Importa any inju	21. Signature of an a Service Hensee 22. Name and Address of Facility Hardesty Funeral Home P.A. Gambril									
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it	Physician/Me	in the past 12 months? 1 \(\text{Yes} 2 \square \text{No} \)	f yes, outcome of pregnan Live Birth 2 Fetal Pregnant at time of de	ncy death 3	Ectopic pregnan			23d. Da	te of delive	ry Day Year
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	the Hospi iin 24 hou the Funer ipleted fill	Medical	29a. Certifier (Check Check Ch	To the best of my knowle on the basis of examination of control To the basis of my	edge, death and/or inves	occured at the time tigation, in my opini	e, date and place, ar on, death occurred a le time, date and pla	nd due to the caus It the time, date an	se(s) and mann d place, and du	er as stated e to the caus	l. se(s) and manner stated.
	vith To t		29b. Signature and title of certifier	ated cause of death (Item 32. Registrar's Signatu		29c. Licens	e number D 6523	ϕ	9d. Date signe	3/C	ay, Year)
(1454		30. Name and address of person who comple	eted cause of death (Item	23a) (Type, I	Print)	edical	PKwy	Anno	you!	, MD
	Stat Registra		31. Date filed (Month, Day, Year) 0CT 14 2009	32. Registrar's Signatu	lire 1	back					U.S.

Funeral Director

Division of Vital Records, P.O. Box 68760,		
To the Hospital or Attending Physician: The law requires that the death certificate be executed	Ph // Ex	
within 24 hours after death.	y: Ma	
To the Funeral Director: After this certificate has been signed by the attending physician and	sic ed m	
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r	4a. Facility Name (If not instituti	ion, give street and n	umber)		4b. City,	Town, or	r Location			4c.	County of E		
	PENINSULA	KEGIONAL				1 /2 24			BURY				rico
	5. Social Security Number	6.9%ex 1 □ M 2 ☑ F	7. Age (In yrs. 88	. last birth Y	Months	Days	Hours	24 Hrs. Min.	8. Date of E (Month, I	Birth Day, Yea <i>r)</i>		Coun	
	219-01-3286 Usual Residence of Decedent	21	00						June 8	3, 192	21 Mā	ary.	and
1	10a. State 10b. Count	ty	10c. Ci	ity, Town	or Location						<u> </u>	10	d. Inside City Limits
	Maryland Wor	cester					Berl	in					1 X Yes 2 □ No
	10e. Street and Number	00000			10f. Zip	Code				10g. Citi	zen of Wha	t Count	try?
	1 Meadow Stree	> +				21	.811				USA	X	
	11. Marital Status	12. Was Dec	edent Ever in U	J.S.	13. Was Deced			igin? (Spe	ecify Yes or N	10-	14. Race - /		
	1 ☐ Never Married 2 ☐ Ma	Armed F	2 No		1 ☐ Yes 3		an, iviexicai Specify.		Hican, etc.)		Black, V		ite
	3 Widowed 4 ☐ Divorce	ed If Yes, G Year or I			I Lites	- ÇĄ INO	Specify.				Specify:	V V I I	1100
	15. Decede (Specify only high	ent's Education lest grade completed)	1 6	Decedent's Usua Give kind of wo	rk done i	durina mos	t of worki	ng	16b. Kii	nd of Busin	ess/Ind	ustry
	Elementary/Secondary (0-12)	College	(1-4or 5+)	7	life. DO NOT us	se retired	d)					_	
	17. Father's Name (First, Middle	- (+)			Nurs	e	10 Math	ava Nama	(First, Midd		spita Surnama)	ı.L	
										ie, maideri	Surname)		
	Edward Riggin			100	Martina Addison	(04		·1 Ne		-1 0:	- T C4-	4- 7:-	Cadal
	19a. Informant's Name/Relation		lac	- 1	Mailing Address Oceans						r Iown, Sta	te, ∠ıp	Codej
ì	Darlene Stever	is (Daugiic			Disposition (Nar		_ Der		Date		cation - City	or To	wn. State
	1 ☑ Burial 2 ☐ Cremation		State	cemetery, -	crematory`or o	ther plac							
	4 Donation 5 DOther		AS	bury	Cemete		1		/2009				Maryland
	21. Signature of Funeral Service	e Licensee	1 Colut	1	22. Name an			DIVE					L HOME
1	306 W. Main Street - Crisfield, Ma										d, Mar	УТа	Approximate
1	23a. Part 1. Erfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a.	olon		ance	Y						4	
	reading in dealing		o (or as a consec	1.									
	Sequentially list conditions, b. Pancytopenia												
Sequentially list conditions, if any leading to know data cause. Enter Underlying Cause (Disease or injury													
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a none-quence of): Due to (or as a consequence of):													
l		d											
	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn								23d. Date o	f delive	irv
	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pre	birth 2 - Feta gnant at time of		3 ☐ Ectopic p 5 ☐ Other (sp		СУ			.	Month		Day Year
	9 ☐ Unknown	9 □ Unk	nown										
	Part II. Other significant condi	tions contributing to	death but not res	sulting in t	the underlying c	ause giv	en in Part		23e. Die	d tobacco u	se contribu	te to th	e cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No										2 No 3[Prob	ably 4 ☐ Unknown	
I					24a. Was an 24b. Were autopsy findings avai				osy findings available				
									_ pe	topsy rformed?	dea	th?	npletion of cause of
1	25. Was case referred to medic	eal					26 Place	a of Death	1 ☐ Yes ∩ (Check onl)		1 1 1	Yes	2 □No
	examiner? 1 ☐ Yes 2 ☐ No	Hoopital	Inpatient 2	TEB/Outr	natient 3□DC	Oth	OF:		me 5□Re		S □Other (Snacifi	<i>(</i>)
ł	27. Manner of Death	28a. Date	of Injury	28b. Tit		8c. Injur Worl			28d. Describ			оресп	
ı	1 Natural 5 Pend 2 Accident inves	ling (Mo. stigation	nth, Day, Year)	inj	ury M		κ? lYes 2. □	No					
ı	3 ☐ Suicide 6 ☐ Could	mined 20e. Flac	e of Injury - At h		n, street, factory	, office						r Rura	l Route Number,
	4 ☐ Homicide deter	build	ding, etc. (Speci	iry)					City or T	own, State	,		
	29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medica	/Ing Physician: To the al Examiner: On the and ma	e best of my kn basis of examin nner stated.	owledge, ation and	death occurred /or investigation	at the ti	me, date a opinion, de	nd place, ath occur	and due to the time	ne cause(s) ne, date and	and mann I place, and	er as s due to	tated. the cause(s)
1	29b. Signature and title of certif	ier			290	29c. License number 29d. Date signed (Month, Day, Year)							
	Desay . M	1.0.			1	57	195	2_		10/	14/	09	4
-	30. Name and address of person	on who completed cau	use of death (Ite	m 23a) (T			-						
	Babulal Das		ford ST	.#	504B.	Sal	isbni	ny.	MDZ	180	1		
	31. Date filed (Month, Day, Yea	r) 32.	Registrar's Sign	ature									
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0.4		V	-	1	7								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34741 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Enna Espinal 10 2009 4:03pMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1004 Plover Drive Halethorpe Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Honduras 1 □ M 2 X X Hours 05/20/1975 Director 34 None Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 XYes 2 No Hudson Union City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 07087 Honduras 1101 New York Ave. Apt. 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Honduras If Yes, Give Specify: Hispanic 3 Widowed 4 Divorced Completed Year or Dates id Mental Hygiene. marked other than "natui matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Labor Factory 9th other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Consuelo Pineda Rutilio Espinal if. Page 1 and 2 shours of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 New York Ave. Union City, NJ 07087 Francisco Escobar/Husband permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Bemoval from State 10/21/09 General Cemetery Honduras 4 Donation 5 Other (Specify) natur Funeral Service Licensee 22. Name and Address of Facility John T. Rhines Funeral Home D.C. 3005 12th. St. NE Wash. 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ utenine disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached לחייות Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an has page 2 autopsy perform certificate 25. Was case referred to medical examiner?

1 X Yes 2 No 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\tilde{\text{N}}\) Other (Specification) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one ٩ 29c. License number 29d. Date signed (Month, Day, Year) 1866 (Item 23a) (Type, Print) Trimb 31. Date filed (Month, Day, Year, Registrar's Signature State

Registrar

16

	1	For State of Mary State Registrar	•	ertificate of L		Mental Hy	giene Reg. No. 20	09	34742	
Physician Medica	/	Decedent's Name <i>(First, Middle, Last)</i> Mary Louise Elliott	le:		2. Date of Dea		3. Time of Death 9:30 Р м			
Examine		a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, o	r Location of Death	4c. County of De			el	
Funeral Director	Ę	. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) 6 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt		ace (State or Foreign		
and show at		Jsual Residence of Decedent 10a. State 10b. County 10	c. City, Town or L	ocation				10	0d. Inside City Limits	
e Maryk r 28a-f : notified		MD Anne Arundel Oe. Street and Number	Arnold	10f. Zip Code			40- 00	fla a h Carrina	1 🗆 Yes 💥 🗆 No	
leath with the Maryland items 23a or 28a-f sho er must be notified at	<u> </u>	257 Shore Acres Road		21012			10g. Citizen of W		rry?	
° L.S		1. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.	in U.S. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e W		
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, the Medical Exam	completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired) emaker	during most of work	ing	16b. Kind of Bu		ustry	
yland and a be filed we wental Hygarked othe attic event,		7. Father's Name (First, Middle, Last) John Sommer			18. Mother's Nam Philomin)		
Mary d 2 shoul alth and 1 27 is m	- 6	19a. înformant's Name/Relationship (Type, Print) Donald L. Elliott SON	1	ling Address (Street Shore Acr				tate, Zip Co	ode)	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	2	20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp Hillcre	position (Name of ematory or other place ST Cemete	ry 10/0	Date 06/09	20c. Location - Annapol	•		
Balt permit Depart Import any inj		21. Signature of Europal Service Mensee		22. Name and Addre Hardesty	ss of Facility Funeral H	lome P.A	. 12 Ric	lgely Pis,	MD 21401	
Physician/ Medical		23a. Part 1. Ento the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a cc	sis	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
Examiner	<u>.</u>	Sequentially list conditions D.	Put (o as a consequence of):							
recuted and al-transit	Yall	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a co	onsequence of):					1		
60 ate be ex physician the buria	5	d								
ox 687 ath certifica ttending procure as	Iyalcıalı'ı ivie	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of a limit of the past 12 pregnant at ting 1 Unknown 23c. If yes, outcome of a limit of the past 12 pregnant at ting 1 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Dat Mor	e of deliventh	ry Day Year	
ords, P.O. Bo	בֿב	Part II. Other significant conditions contributing to death but r	re			23e. Did to	_/		e cause of death? ably 4 Unknown	
Division of Vital Records, tal or Attending Physician: The law requires is after death. al Director, After this certificate has been signed in by the funeral director, page 2 should be a large of the funeral director, page 2 should be considered.		perighered vas	cular	disea	SL	24a. Was autor perfo 1 Yes	rmed d		sy findings available inpletion of cause of	
Vital hysician: his certific I director,	מ מ	25. Was case referred to medical examinar? 1 Yes 2 No Hospital: Inpatient	2 🗆 ER/Outpati	_ Loth	lace of Death (Checier:		ience 6 🗆 Othe	r (Specify)		
on of ading Ph tth. : After th		27. Manner of Death 1 Natural 5 Pending (Month, Day, Ye 2 Accident Investigation	ear) 28b. Time injury	work	y at		ow injury occurre			
ivision of lor attending P after death. Director: After t in by the funera		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. (S		treet, factory, office						
Division of Vital Rec To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the besent of my	nination and/or inve	stigation, in my opini	on, death occurred a	it the time, date a	nd place, and due	to the caus	se(s) and manner stated.	
To the To the Community		29b. Signature and title of certifier Mww.d. A. D. T.	0	29c. Licens	65117		29d. Date signed	1/2	ay, Year)	
(43)	1	30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	MD	21401	· M		a Saenz	
State Registrar		31. Date filed (Month, Day, Year) 0CT 14 2009 32/Registrar's	Signature	arke						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^D 12 2009 OCTOBER **EVANS** 10:20P M MARIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VILLA ROSA NURSING HOME FEDERALSBURG CAROLINE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAY 5 1912 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 97 213-22-8932 Director MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Profiles Exp. it are rest to notified. Director 1 X Yes 2 □ No PRINCE GEORGE'S BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20721 3800 LOTTSFORD VISTA ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK If Yes, Give 1 ☐ Yes 2K No Specify þ Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE KNITTING MILL 9TH 12 should be filed with and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDITH THOMAS WINDFIELD MAGEE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an CAROLIN V. MATTHEWS/NIECE 801 J. P. HARRISON BLVD KINSTON, NORTH CAROLINA 28501 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Removal from State 4 Donation 5 ☐ Other (Specify) FEDERAL HILL CEMETERY 10-19-09 FEDERALSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYPERTENSION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions r any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of ADULT FAILURE TO THRIVE Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) burial Box 68760. physician Physician/Medical as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy Ď in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 📉 No Ö ed by the detached 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ঢ় No 2 🙀 No After this certification, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖳 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No hours after deatl uneral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) and title of certilier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 12, 2009 D32261 COM who completed cause of death (Item 23a) (Type, Print) RICHARD FELDMAN M.D. 9500 ANNAPOLIS ROAD A-4 LANHAM, MARYLAND 20706 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Fofano Month 1400 2009 rodow 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Univ Manylond Medical Center WD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 62 yrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Hours Days Months 1 ☑ M 2 □ F 577-78-4336 June 12, 1947 Sierra Leone Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 1KTYes 2□No Brookville Md Montgomery 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 20833 USA 3025 Quail Hallow Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 28 Married 1 ☐ Yes 2 X No Specify: Black Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Restaurant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. Mustapha Fofana 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3025 Quail Hallow Terrace, Brookville, MD 20833 Marie Fofana / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 10/09/2009 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final Gostrointestral blog disease or condition resulting in death) Due to (or as a consequence of): coltis Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? heart 5100 CONSEZ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) Hospital: npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

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Hospital 24 hours a

physician

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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27

parmit. Pages 1 a
Department of Her
Important: If Item
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1 and 2 should be Health and Mental ?7 Is marked of traumatic even

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Director

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Completed by

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

		to medica	ш
xaminer	?		
☐ Yes	No		
	222 2		

27 Manner of Death Natural 2 Accident

4 Homicide

5 Pending 3 ☐ Suicide

investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the desired o and manner stated. 29b, Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Herr 31. Date filed (Month, Day,

OCT 1 5 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marv Forsythe Oct 13 2009 6:35p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Larkin Chase Nursing Home Bowie, MD
If Under 1 Year | If Under 24 Hrs. Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □XF Hours 246-36-8027 85 **Director** 16 0ct 1923 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Exerciper aust be notified at Director MD 1 Yes 2 □ No Charles County Indian Head 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 Marvin Drive 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7 th College (1-4or 5+) Factory Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F Braswell Curtis ဂ Francis Forsythe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Davitta Ealy/grand daughter 3905 Marvin Drive, Indian Head, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ment of I ☐ Burial 2 Cremation 3 ☐ Removal from State Riverdale Crematory 10-15-2009 Riverdale, Maryland 4 Donation S Oner (Specify) 21. Sign Funer Service Licensee J. B. Jenkins Funeral home 22. Name and Address of Facility 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner aediac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, physician the buria Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes € No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
 □Yes 2♣No 24a. Was an autopsy page certificate 1 □Yes 2 □No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated

State

Aditya Chopra OCT 1 5 2009

29b. Signature and title of

M.D 600 Ridgely Ave Ste 231 Annapolis MD 32. Registrer's Sign

30. Name and address of per who completed cause of death (Item 23a) (Type, Print)

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Month **Physician** Marie 200 1033 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 45 Days 460-15-1720 exas March 18 **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 28a-f show Examiner must be notified at 1 ¥ Yes 2 □ No Dallas Director town 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? 23a or USA van Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates 1 ☐ Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 2 No þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Secretar and Mental Hygiene. Medica 17. Father's Name (First, Middle, Last Mother's Name (First, Middle, Maiden Surname Be ည injury or other traumatic 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Fraulyn Department of Health a Important: If item 27 is any injury or other trainonce. Dallas 701 TOWN Michae 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Netzel Funeval Home 4 Donation 5 Other (Specify) Signatul > Austin H. Eberly V Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Difficik **Physician** week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perforn 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 1 Yes 2 No nours after death.

neral Director; After this ce
filled in by the funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury

"facth Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 🗌 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

WIL 10

> State Registrar

ueso

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

Potob-k

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene, 34747 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) **Physician** 2009 5:05 p M Robert Michael Gasior October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 11, 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 **M** M 2 □ F 51 1958 Maryland 213-80-2453 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Carroll Taneytown Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21787 6 Windy Hills Drive USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Postal Service Mail Handler 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Rita Wisniewski Robert E. Gasior ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Windy Hills Drive, Taneytown, MD 21787 t of Health if item 27 i Kerri Gasior, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/12/2009 Taneytown, MD Joseph Cemetery 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Sign, ture of Funeral Service Licenses 136 E Baltimore St, Taneytown, MD 21787 · Lar Approximate Interval Between Onset and Death . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Firator /Medical Due to (ows a consequence of Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ NO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 1No 1 Yes funeral director, Be 26. Place of Death (Check onle one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient Certification: To After this 27. Manner Loath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 -Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature a d title of certifie 30. Name and address of person who completed cause of Edward A. Saus 116 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 2009 06 0358 October Helen Naomi Gist /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) July 27 1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 7 F MD 89 **Director** 213-38-7701 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 No Director Pleasant Valley Maryland | Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1901 S. Pleasant Valley Rd. 21158 USA. Funeral I and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify. ۵ Specify: White 3K Widowed 4 Divorced "natural" Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker raumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Geary Angell Winnie Harner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1903 S. Pleasant Valley Rd. Westminster, MD 21158 Michael Gist 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 • **±** ò 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Pleasant Valley Cem. 10/9/2009 Pleasant Valley, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses 2Pritts of the Fair Home and Chapel, P.A. Mili 21157 Westminster, MD 412 Washington Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician eubmy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bilahou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CH Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐Yes 1 ☐Yes 2 ☐ No 2 🗀 Ne Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Owner (Specify) No VE 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner Death 28c. Injury at Work? . Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred HOUSE After t 1 Matura 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29h. Signature of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 349 Mad calm Kahena

State Registrar 31. Date filed (Month, Day,

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32. Registrar's Signature

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	Funeral		5. Social Security Number 6. Sex	M 2DF	(In yrs. last birthday)	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Cou			
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	th the or 28¢	Director	10e. Street and Number			10f. Zi	p Code		1	0g. Citiz	Citizen of What Country?			
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F	OKW		30. Name and address of person who cor	moleted cause of des	oth (Item 23a) (Type	Print)					-/.5/.			
L	0 10	1	Chang Choi, M.D.,			,	ce Fr	ederick.	MD 206	78				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature									
	Registr	ar	OCT 162009 /2	1	Show W. B									

			For State Registrar	State of Mary		artment of F rtificate of I		ental Hyرا ا	Reg. No. 200	9 34750		
	Physici /Medic		1. Decedent's Name (First, Middle, L	GARFIEL	DHAR	RIGAN		2. Date of Dea Month		3. Time of Death		
	Examin		4a. Facility Name (If not institution, g	give street and number)			Location of Death		4c. County of Dea	ath		
	Funeral Director		5. Social Security Number 6. 580-07-9777		yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day MARCH	h 9. Bi	rithplace (State or Foreign ountry) RGIN ISLAND		
	e Maryland 8a-f show diffed at	Director	Usual Residence of Decedent 10a. State 10b. County MD PRINCE	GEROGE'S	c. City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No		
	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, i'rs Modical Exacting in the last coffind at	Funeral Dire	10e. Street and Number 4301 RUSSELL AVE 11. Marital Status	NUE #A-1	in U.S. 13. \	10f. Zip Code 20712 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp		10g. Citizen of What CUSA			
0036	nours after oural", or Iter	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 💢 No	Specify:	Ricán, etc.)	Specify: B	LACK		
21215-0036	I within 72 h giene. r than "nati r s Medica	Completed	15. Decedent's (Specify only highest g	Education prade completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work 1)	ing	16b. Kind of Business PRIVATE	industry.		
Maryland	ev d	To Be C	17. Father's Name (First, Middle, Las FRANZ ALEXANDER						Maiden Surname) A MONSANTO			
	nd 2 s allth ar 27 is rtrau		19a. Informant's Name/Relationship JUSTIN HARRIGAN	SR./HUSBAND	4301	RUSSELL	AVENUE #A	A-1 MT.		YLAND 20712		
Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	20b. Place of Dispo cemetery, cren	CEMETERY	#1 10-23		20c. Location - Sity of ST. CHARLOTTE	MALALIE		
g n	Department of the control of the con		23a. Part 1. Enter the disease, or co	7	7	16 KENNED	Y ST N.W	. WASHIN	JENKINS FU			
- VE	Physician /Medical Examiner		shock, or heart tailure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	ole My	e lom a		or respiratory ar	rest,	Interval Between Onset and Death		
,	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire, Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co								
	as at	ledical	OF FEMALE.	d	_				1			
P.O. Box	t the death certific by the attending p ached for use as t	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year		
ecords, r	requires that the peen signed by th hould be detache	ğ	256. Did lobacco use contributions to death but not resulting in the underlying cause given in Part.									
Yec Yec	The law ate has b	- Completed	25. Was case referred to medical) 0'			26. Place of Deat	24a. Was a autop perfor	prior to death? 2 \(\text{No} \) 1 \(\text{Ye}	utopsy findings available completion of cause of		
OT V	nding Physician: th. : After this certifica ? funeral director, p	: To Be	examiner? 1 ☐ Yes 2 ☑ No		2 ER/Outpatien		er: 4 🗆 Nursing H	ome 5 Resid	lence 6 ☐ Other (Sp	ecify)		
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28c. Place of Injury At home, farm, street, factory, office 28c. Injury at Work?									
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of m aminer: On the basis of exa and manner stated.	y knowledge, death amination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)		
•	Vithii O To th	Me	29b. Signature and title of certifier Saluylusau	hi har, MI)		006370	3	29d. Date signed (Mon	2009		
_	fo R		30. Name and address of person wh	H WAR		Print) 7	GOO CA ROMA	PARK;	MD			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 6 2009	32. Registrar's	Signature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year 10:10am 2009 Elise Michelle Gist 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Lanham Doctor's Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 □ M 2 🔀 F Maryland 4 Yrs 218-71-6770 February 21, 2005 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits X1X Yes 2 □ No **Bowie** Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7417 Quixote Court 20720 U.S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status

1 ☐ Yes 2√2 No

Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

3 Ectopic pregnancy

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

5 ☐ Other (specify)

7417 Quixote Ct., Bowie, MD 20720

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line.

African American

none

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes

2 0 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 Tyes

24a. Was an autopsy performed 2 **2** No

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Brentwood, MD

18. Mother's Name (First, Middle, Maiden Surname)

Nicole Gist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

October 19, 2009

Bonnette & Assoc. Funeral Hm 2504 28th St., N.E., WDC

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

1 XNever Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

none

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print) Nicole S. Gist-Mother

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

Mark Stephens

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

2200

5 ☐ Pending investigation

6 Could not be determined

IF FEMALE:

17. Father's Name (First, Middle, Last)

21. Signature of Funeral Service License

1 ∐Yes 2 ☑ If Yes, Give Year or Dates:

College (1-4or 5+)

2 No

John F. Bolden

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

4 ☐ Pregnant at time of death

MD

Director

Funeral

Š

Completed

Be

ပ

Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Funeral

Director

28a-f show

"natural", or items 23a or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ins. Ma.

traumatic event, the Medical Examiner must be notified at

death with the Maryland

3altimore, Maryland 21215-0036

and burial-trar attending physician for use as the buria

Division of Vital Records, P.O. Box 68760. the Hospital or Attending Physician: The law requires that the death certificate be death. 24 hours a

State Registrar 2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar		State of Ma	aryiand /	Cer	irtment of F tificate of E	ieaith and Death	ı Mental Hy	/gien Reg. N	E. U U	9 34752
	Physicia		1. Decedent's Name (F Andrew F.			2. Date of D Month		year .5 200	3. Time of Death				
	Medic Examin		4a. Facility Name (if no	4b. City, Town, or	Location of Dea	1 10 ath		.5 200 c. County of Dea					
und!			Gilchrist 5. Social Security Num	Hospice		(In yrs. last bi	irth day)	Towson If Under 1 Year	If Under 24 Hr	s. 8. Date of B		Baltimor	
Н	Funeral Director		212-86-576	66 1	M 2 □ F / . Age	44	Yrs.	Months Days	Hours Min		/196	54 g. Bi	rthplace (State or Foreign ountry) FL
pue	show	tor		0b. County		10c. City, Tox	wn or Loc	ation					10d. Inside City Limits
Mary Value	r 28a-f notifie	Direc	MD I	Baltimore	9	Arbutu	as	10f. Zip Code			40. 6		1 ☐ Yes 2 🗷 No
with th	is 23a o	Funeral Director	1223 Brews					21227			US. C	Citizen of What C	ountry?
land 21215-0036 he filed within 72 hours after death with the Maryland	tal Hygiens. 2 nous are beau with the waryand tal Hygiens than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 3 Widowed 4 [d 2 ⊠ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.		lf	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛛 No	n, Mexican, Pue	Specify Yes or No irto Rican, etc.)	l -	14. Race - Am Black, Whi Specify: Wh	te, etc.
OSOO-CLZLZ	e. nan "nat	Completed		15. Decedent's Edi y only highest grad day (0-12)		, -	(Give k	ent's Usual Occup ind of work done of NOT use retired)	luring most of w	-		Kind of Business	
בא ליי	Hygien Sther th	Be C	17. Father's Name (Firs			´ F	rodu	ct Servi		clate ame (First, Middle			panies, Inc.
Maryland	silould be ind and Mental I 7 is marked o raumatic eve	뎯	Alan Halla						Arlene	Weinste	in	r Gurriamey	
, Mar	nozsnou saith and n 27 is m er traum		19a. Informant's Name Susan Hal		*	1		g Address (Street a B rewster					lip Code)
Baitimore,	age rail nent of He int: If iter iry or oth				Removal from State	cemet	tery, crem	sition (Name of latory or other place remation		Date 19/2009		Location - City o	
Balt	permit: rager and zshould ber Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signal 1. of Funer				22.	Name and Address	s of FacilityHa	rry H. W	itzk	e's Fam	ily FH, Inc.
*1.21	rysician/		shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Medical xaminer		resulting in death) Due to (or as a con v quence of):										
ted	nsit	Examiner	Sequentially list condi if any, leading to imme cause. Enter Underlyii Cause (Disease or iin)	ediate ing	Due to (or as a	consequence of):							
/ ou cate be executed	sician and burial-tra	cal Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
570U	ng phys as the	Medical	IF FEMALE:		d								
he death certifi	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pre in the past 12 mo 1 Yes 2 N		Ectopic pregnanc Other (specify)	у			23d. Date of delivery Month Day Year				
IS, P.C.	n signed b ıld be deta	by	Part II. Other significa	ant conditions cor	ntributing to death be	ut not resulting	in the ur	nderlying cause giv	23e. Did tobacco use contribute to the cause of c				
ecords, le law require	e has been si ige 2 should I	Completed								perl	opsy ormed?	prior to death?	utopsy findings available completion of cause of
VITAI IT ysician: Th	ertificat ctor, pa	Be Co	25. Was case referred examiner?		1			26. Pla	ace of Death (Ch	1 □ Yes neck only one)	2 🔀	No 1	es 2 No
OT VIII ng Physic	rthis ce ral dire	욘	1 Yes 2 X	40 H	lospital: 1 Inpatie	ent 2 🗆 ER/0	Outpatient	DOA Othe	4 ☐ Nursing	Home 5 Res		7	city hospice
on c	eath. or: Afte the fune	Certificate:	2 Accident	5 ☐ Pending Investigation 6 ☐ Could not be	(Month, Day		injury	work	? Yes 2 □ No	200. Describe	now inju	my occurred	
JIVISION al or Attendir	s after d al Direct ed in by t		4 Homicide	determined	28e. Place of Inju building, etc		farm, stre	et, factory, office		28f. Location City or To			ural Route Number,
l ne Hospit	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 3	Medical Examin	cian: To the best of our cer: On the basis of exercioner: To the basis	amination and	or investi	gation, in my opinio	n, death occurre	d at the time, date	and plac	e, and due to the	cause(s) and manner stated.
Totl	with		29b. Signature and title	e of certifier	lus			29c. License	number \$83	03	29d. Da	ate signed (Mont	th, Day, Year)
			30. Name and address	of person who co	ompleted cause of de	eath (Item 23a)	(Type, Pr	(A)C	harle	12 8	T	in sun	M
	Stat Registra		31. Date filed (Month, I	10 Year 1 6 2	(1)(19 2)	r's Signature	1. 1	ake			,		

		1	State of Maryland / Department of Health and 1- For State Registrar Certificate of Death	Mental Hy	gien 2 Reg. No.	009	34753
			1. Decedent's Name (First, Middle, Last)	2. Date of Do	aath Day	Yeer	3. Time of Death
į	Physicia /Medic		IDAMAY FRANCES HARPER	10-1	2-200		10:00 P M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	th	3.6	ounty of Deat	
			Springbrook Nursing & Rehabilitation Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8 Date of Bi		ntgome:	hplace (State or Foreign
	Funeral Director		578-48-1872 1 M 2 M F 73 Yrs. Months Days Hours Min	8. Date of Bi (Month, D 12-11	ay, Year) -1935	Was!	hington,DC
			Usual Residence of Decedent				10d. Inside City Limits
	ith the Marylan or 28a-f show	_	10a. State 10b. County 10c. City, Town or Location				XXYes 2 □ No
	Ba-f.	2	Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code		10a Citize	en of What Co	untry?
	with t	5			USA		,
	leath ns 23	era	12325 New Hampshire Avenue 20904 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N		I. Race - Ame	
220	s i and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "netural", or Items 23e or 28e-f show other traumatic event, the Medical Examinations be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No If Yes, Sive 1 Yes Cive 1 Yes 2 No Specify:	rto Hican, etc.)	s	Black, White Specify: Wh	
	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking	16b. Kind	d of Business/	Industry
V	nithin nan Mer	mple	Elementary/Secondary (0-12) College (1-4or 5+)		0	II	
7	ited w Hygler Ihar th		12th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ame (First, Middle		Home_	
2	d be findal h	Be	John Franklin Croft Eva Na				
	2 should be filed with and Mental Hyglene. Is marked other than surmatic event, the M	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		ber, City or	Town, State, 2	Zip Code)
2	and 2 sealth ar n 27 is		Lillian May Harper/daughter 3810 26th St., NE, Wa				
altimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tre		20a. Method of Disposition 1 XBurial 2X Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 10-	Date 14-2009		ation - City or 1 and , $$ $$	Town, State Maryland
Dailli	permit. 8 Departm Importar any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility May Hedgman M0/374 Cedar IIII FII, 411	l FA Ave	., Su	itland	, MD 20746
	X0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardisahock, or heart failure. List only one cause on each line.	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
*	Physician		Immediate Cause (Final disease or condition a. Vascular Demen \$76.				Many Yrs
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	9,	70	Sequentially list conditions, it any leading to immediate b. Due to (or as a consequence of):	<u></u>			rigny yrs.
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. DOX	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes}, \text{ outcome of pregnancy} \) 1 \(\text{Yes}, \text{ outcome of pregnancy} \) 1 \(\text{Yes}, \text{ outcome of pregnancy} \) 1 \(\text{Live birth} \) 2 \(\text{Fetal death} \) 3 \(\text{Ectopic pregnancy} \) 4 \(\text{Pregnant at time of death} \) 5 \(\text{Other (specify)} \) 9 \(\text{Unknown} \)		20	3d. Date of de Month	livery Day Year
	that the od by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Dio	tobacco us	e contribute t	the cause of death?
cords,	uires I sign Id be	d by	Hypertension, Renal Insufficiency,	10	Yes 2	No 3□P	robably 4 Unknown
5	w req	Completed	obesity.	24a. Wa		24b. Were a	utopsy findings available completion of cause of
ב	fhe la te has age 2	E O		aut per 1 \(\) Yes	opsy formed? 2 No	death?	s 2 No
VII	rsician: The law s certificate has b lirector, page 2 s	0		eath (Check only			
	nysici nis cer direc	To B	examiner? 1 Yes 2 No	Home 5□Re	sidence 6	□Other (Spe	ecify)
5	ng fte ine		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe	e how injury	occurred	
Sion	Attending or death, ector: After by the fune	catl	2 Accident investigation M 1 Yes 2 No	20f Longtion	(Stroot and	(Number of E	ural Route Number,
2	or At after d Direct in by	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		own, State)	7744111267 07 71	urar riodie rvanicer,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla 2 man manner stated.	ce, and due to th curred at the time	e cause(s) a e, date and	and manner a place, and du	s stated. e to the cause(s)
	o the o the omple	Med	29b. Signature and into of gentifier. 29c. License number				th, Day, Year)
	⊢≯⊢ŏ		D31001		10	0-13-20	009
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			Stuart Turkewitz, MD 7500 Greenway Center Dr.#403,	Greenbel	t. MD	20770	
-	3		Stuart lurkewitz, hb 7500 Greenway Center br. #405,	or combo-	,		
	Sta Registr	-	31. Date filed (Month, Day, Year) OCT 1 5 2009 Control of Period Greenway Certical Dr. #403, 10 are filed (Month, Day, Year) OCT 1 5 2009 Control of Period Greenway Certical Dr. #403, 10 are filed (Month, Day, Year)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34754 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ctobur 7, 200G William Robert Jones /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 65 Khr Baltimore Washington Medical Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 15, If I In 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 212-05-9565 1 X M 2 □ F Months Days Director 89 T919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show a or 28a-f show 10d. Inside City Limits MD Director Anne Arundel Pasadena 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or ? item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examinations to 833 De Franceaux Harbour 21122 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married WW II Specify: White 1 ☐Yes 2 X No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R. Jones, Sr. Clara Schneider ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Jones/Wife 833 De Franceaux Harbour Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, MD 21. Signature of Funeral Se 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 00 disease or condition resulting in death) 28 /Medical Due to (or as a sensequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit and Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 1 ☐Yes 2 ☐ No 5 Other (specify) a ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 □Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

The law requires that the death certificate be Box (Records. peen has certificate Division of Vital or Attending Physician: Hospital

the Maryland

Baltimore, Maryland 21215-0036

this s after death.

I Director: After this of in by the funeral d within 24 hours aft

To the Funeral Di

completely filled in To the I within 2

State

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50

distrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 10 /Medical Kathleen S. Johnson October 0 8:55a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Community Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔯 F 90 Director 143-18-1811 11/29/1918 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Prince George's 1x Yes 2 No Bowie Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20716 USA 16010 Excalibur Road #B301 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 □Yes 2√⊋No Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education Media Center 12 should be filed within 7 h and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) of the DC Public Schools Film Library Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin P. Spencer Effie Green ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Eloise Jackson Branche - dtr 1619 Portland Lane, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/20/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home B401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (r as a consequence of): INTRACEREBRAL BLEED Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner PIGHT INTRAVENTRICULAR HEMOREHAGE

Je to (or as a consequence of):

ANDREW

AN burial-transi attending physician and for use as the hirial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>\$</u> HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☑No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred Fell Inhome 28b. Time of Injury h 27. Manner of Death To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Certification: After Division 1 ☐ Natural 2 🗶 Accident 5 Pending investigation 10 Kitchen het her neace 281. Location (Street and Number or Rural Route Number, City or Town, State) 16010 Excall burkd Oct. 9, 2009 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ome # B-301 BOWIE NO *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00067810 109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDDIOUIE PRINCE GEORGES 32. Registrar's Signature ed (Month, Day, OCT 1 5 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 200 ava 0 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** atthre 10 Dice Lake omico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours Min. 217-90-5346 **Director** 02-13-1952 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29353 Fairmount Road 23a 21871 Funeral USA Items : 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 9 Own Home none Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Lowe ၉ Janet Lowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Gilead, Ohio 6818 US 42 43338 Crystal Ann Nichols/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Salisbury Crematory 10/08/2009 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) lignature of Funeral Section Lio Insee 22. Name and Address of Facility Hinman Funeral Home - M00295 11673 Somerset Ave. Princess Anne, MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final LUNG **Physician** MALIGNANT CARCINDUL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any least of the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical s been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of certificate has birector, page 2 sl autopsy perform Division of Vital 1 ☐Yes 2 HNO Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSP (CA 1 Yes 9 No After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation I hours after death. uneral Director: Af ely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after
To the Funeral Dire
completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 e Hulotin 30 WAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:18 P^M William Henry Knight, Sr. October 9, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park

Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 10 Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Yrs. Sept. 1, 1918 North Carolina 578-16-1290 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director Maryland | Prince Georges Forestville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 1855 Addison Road South United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 K Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Taxi Driver Taxi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ Yeleveron George Knight Beatrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Smith/Daughter 11715 Bishop's Content; Mitchellville, MD 20721 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/16/09 Suitland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Seprice Licensee Simple Tribute 1040 Rockville Pike; Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fight failure. It is only one cause on each line. Immediate Care (Final disease or condition resulting in death) **Physician** neumoni /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-transit and Due to (or as a consequence of): inding physician ause as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate funeral director, page 2 **X**-No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred I or Attending P after death. To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tite of certifier D45660 th (Item 23a) (Type, Print) T Lex (N, 124 Bog 30. Name and address of person who completed cause of CALLANT fex 3CC, 82. Registrar's Signature 31. Date filed (Month, Day, Year) State 16 2009 Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death To the within 2

Funeral Director: etely filled in by the

Medical

Deputy Chief Medical Examiner Jack Titus MD State Registrar

29b Signature and title of certifie

30. Name and address of perso



and manner stated

who completed cause of death (item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 12, 2009

DHMH 17 Rev 1/2001

State Registrar

			For State of	of Maryland	d / Depa	rtment of H	ealth and l	Mental Hy	giene Reg. No. 2 (na	34760
		_	State Registrar 1. Decedent's Name (First, Middle, Last)	·	Cer	tificate of L	Jeatn	2. Date of De		(0)	3. Time of Death
	Physicia		ROBERTA A. LITCH	ESTIN				Month	Day	Year	6:25P M
	/Medic Examin		ta. Facility Name (If not institution, give street and no		ARY AT	4b. City, Town, or	Location of Deatl		4c. County		0.23.
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· · ·	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Ye <i>ar</i>)	Coun	ace (State or Foreign try)
ļ.	Director		386–42–0376 Usual Residence of Decedent	66	Yrs.			Nov 20	1942	Mich:	igan
200	ow at		10a. State 10b. County	10c. City,	Town or Loc	cation				11	0d. Inside City Limits
Man	a-f sh	tor	MD Prince George's	Adelr	ohi						1 □ Yes 2 X No
ţ.	or 28	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
Acot with the Mender	iner within 7.2 mous aren bean with the wayhat tall Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	2209 Lackawanna Street		Lion	20783	1.0110/0	17. 17. 11	USA	ce - America	on Indian
Ž	item:	-une	Armed F	cedent Ever in U.S orces? 2 X No	s. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	to Rican, etc.)	D- 14. Ha Bla	ck, White,	
ر م	al", or	by	If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or	ive	1	I∐Yes 2 X No	Specify:		Speci	^{fy:} Whi	te
3-003b	within 72 hous after ene. than "natural", or ite he Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed	, 7	16a. Deced	lent's Usual Occupa	ation during most of wo	rkina	16b. Kind of E	usiness/Inc	lustry
7	ner B Mec	nple.		(1-4or 5+)	life. L	DO NOT use retired)	9			
N 5	Hygie Hygie ther th		17. Father's Name (First, Middle, Last)	2	Homem	aker	18. Mother's Nar	me (First, Middle	Own Ho		
and	ental l	To Be	Robert Bliesath				Vivian 7			,	
> 3	and Marie maries	F	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a			ber, City or Town	, State, Zip	Code)
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ַ ע	- ± ± =	13	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal fron	ce.	metery, cren	sition (Name of natory or other plac		Date	20c. Location	•	
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Da	Department of Important: If i any injury or once.	i 19	21. Signature of Funeral Service Licensee	6 MO12		ing Home verly L.					784 , MD 21029
ģi;		7	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one suse on	caused the death.	. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
100	hysician	ñ	Immediate Cause (Final disease or condition	EROSCL	EROT	TE CAR	DIOVAS	certa	RDi	SEAS	Onset and Death
	/Medical Examiner		resulting in death)	(or as a conseque	ence of):					7(55) 15-X	6
13		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	i (ui da a curiseque	ence of).					, pr	nh
Po-	d ansit	Examine	Cause (Disease or injury				1		m Jus		
5	ate be executed hysician and the burial-transit		that initiated events c resulting in death) Last Due to	(or as a conseque	ence of):		~ 1	Kry.	V .		
- 5	hysici the bu	lical	d		_	1 3	1	7			
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BOX	atten for us	cian	in the past 12 months?	birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)				ate of delive onth	Day Year
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r,	een signed by the nould be detache		Part II. Other significant conditions contributing to			nderlying cause give	en in Part I.	23e. Did	tobacco use cor	ntribute to th	ne cause of death?
ecord	equire sen siç ould b	leted by	(K) HUMERAL PR	ACTURE				1	Yes 2□ No	3 🗌 Prob	ably 4 Unknown
S S	nas be	uple						24a. Wa auto	psy	prior to cor	psy findings available mpletion of cause of
	icate l	Comple						pen 1□ Yes	formed? 212 No	death? 1 ☐ Yes	2 No
VItal	tending rins is an earth to a section of the funeral director, page 2 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director, page 3 section of the funeral director of the funeral d	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:]Inpatient 2□E	EB/Outnation	t all DOA Othe	or:	ath (Check only	one) sidence 6 □01	h /Oi	
	rthis rald	\vdash	27. Manner of Death 28a. Date	e of Injury	28b. Time of				how injury occu		y)
VISION	Attending r death. ector: After by the fune	atio	2 Accident investigation 500	nth, Day Year)	Injury ぴか	Lance I am	Yes 2 No	5-11			
	ter de irecto	Certification:	3 Suicide 6 Could not be determined 28e. Place buil	ce of injury - At hon ding, etc. (Specify))			28f. Location City or To	(Street and Num own, State)	ber or Rura	A Route Number, ST
ב ב	urs af erai D illed ii		29a. Certifier Certifying Physician: To the	no host of my know		n e	mo data and place	Heelph	i, mi	20	783
100	24 ho	Medical	(Check only 2 Medical Examiner: On the								
To the	within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
			Jasneem La	Cham	m	02	8595		10/13	100	
7			30. Name and address of person who completed car	use of death (Item		- (/	1	-	1	BAC	70
ص	-01		31. Date filed (Month, Day, Year) 32.	M. M. Redistrar's Signati) 28	100g 50	TH MY	E, Sui	E 223	m	10) 21209
	Sta Registr		OCT 16 2009	Enus.	B. 1	backer					

DHMH 17 Rev 1/2001

			1 - State Registrar		,	Cert	ificate of	Death	,	Reg. No.	009	34761
	Di este		1. Decedent's Name (First, Middle, I	_ast)					2. Date of De	eath Day	Year	3. Time of Death
	Physic /Medi		ZitA Le	SCAlles	+				Det	13	2009	1822 PM
1	Exami		4a. Facility Name (If not institution,	ive street and number)		4		r Location of Death			ounty of Death	
age of				spiral (to		Wes-	minst	/		Acrel	
п	Funeral Director		5. Social Security Number 6 471–22–6353	Sex 7. Age	1 (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 11	av, Year)	Cou	place (State or Foreign ntry) Minn
	ъ		Usual Residence of Decedent						0041 ==			
	rylan ihow	_	10a. State 10b. County		10c. City, Tow							10d. Inside City Limits
	a-f s	당	MD Carro	11.	Wes	stmin	ster					1. 20AYes 2. □ No
	permit. Pages 1 and 2 sho Id be filed within 72 hours after death with the Maryland Department of Health and Lental Hygiere. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumetic event, the "Medical Evantine must be neithed an once.	Funeral Director	10e. Street and Number 300 St. Luke Cir	cle			10f. Zip Code 2	1158			en of What Cou USA	ntry?
	ems	le l	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa	as Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	0- 14	4. Race - Ameri Black, White,	
9800	ours afte ral", or it Examin	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced		19431945		□Yes 2□No	Specify:		S	Specify: Wh	nite
5-	72 h 'natu	ete	15. Decedent's (Specify only highest)	Education grade completed)	168	a. Decede (Give kij	nt's Usual Occup nd of work done	pation during most of work d)	king	16b. Kind	d of Business/Ir hildrer	ns Aid and
21215-0036	d within giere. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		NOT use retire cretary	d)			ly Serv	
	al Hy othe vent,	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	ne (First, Middle	e, Maiden S	urname)	
<u>a</u>	ld be enta rked tic er	To E	Albert H. Kryge	r				Anna Lo	retta D	unbar	:	
Maryland	sho s ma		19a. Informant's Name/Relationship	(Type. Print)	19	b. Mailing	Address (Street	and Number or Ru	ral Route Numb	per, City or	Town, State, Zi	p Code)
	and 2 salth n 27 i		Linda Lescallee	t/Daughter	5	5 Fox	Hill C	t., Perry	Hall,	MD 2	1128	
ore	of He fiten		20a. Method of Disposition 1	□ Bemaual from State	20b. Place of cemeter	of Disposit ery, crema	tion (Name of itory or other plac	_{ce)} 10/1	ም/2009	20c. Loca	ation - City or T	own, State
Ē	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Spe		Everg	reen	Memoria	l Gardens		Fi	nksburg	, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lic	ensee				helfal ^{ity} Hon ngton Roa				21157
			23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do			-			er, M	Approximate
	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each lin	e.			fectio.				Interval Between Onset and Death
- april	/Medical Examiner		resulting in death)	Due to (or as a	conse uence	of):	5-32					
		<u>~</u>	Sequentially list conditions,	b Due to (or as a	consequence	ot).					-	
	nsit	흪	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	240 10 (0) 40 0	· comecquemos	, 0.17.						
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):						
68760,	icate be executed physician and the burial-transit			d.								
9	ertifical ing phy e as th	Medical		100								
O. Box	attend for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal deat		Ectopic pregnand Other <i>(specify)</i> _	ey		23	3d. Date of deliving Month	very Day Year
σ.	uires that the de signed by the d be detached t		Part II. Other significant conditions	contributing to death bu	t not resulting	in the und	erlying cause giv	ren in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
of Vital Records,	w requires been sign should be	Completed by	Coronary	Artery I	SCAL	•			1 🗆	Yes 2	No 3□ Pro	bably 4 🗌 Unknown
00	aw requast been 2 should	plet	/						24a. Was			opsy findings available
Ä	The law cate has page 2 s	E O							auto perfe 1 □ Yes	ormed?	prior to c death? 1 ☐ Yes	ompletion of cause of
ital	ician; Th certificate ector, pag	o o	25. Was case referred to medical					26. Place of Dea		one)	7 🗆 100	20110
f \	nysic nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/0	Outpatient	3 □ DOA Oth	er: 4 🗍 Nursing H	ome 5 Res	idence 6	☐Other (Spec	ify)
0 4	ding Physician: h. After this certific funeral director,	Ë	27. Manner of Death 1 ★ Natural 5 Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Inju Wor	ry at k?	28d. Describe	how injury	occurred	
<u>0</u>	death. ctor: A y the fu	atic	2 Accident investigat	on				Yes 2 □ No				
Division	al or Attending Physician; after death. I Director; After this certifical d in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, fa . (Specify)	arm, stree	t, factory, office			(Street and wn, State)	Number or Rui	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examination a							
	To the within To the Comp	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
	WJLA		1118		20		DO	06932	,	Oc	T. 12	2009
	4+11/1		30. Name and address of person wh	o completed cause of de	eath (Item 23a)) (Type, Pr	rint)				- (21157
	4		Matthew N	san, mo	21	201	nemor.	al Av	c. W.	est m	in = 70-	mi
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1. 4	arked				•	2009 21157

		1	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H ertificate of E	ealth and Me Death	ntal Hygie Reg.		34762
	Physicia		1. Decedent's Name (First, Mic	ddle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
~ 1	/Medic	al	HAROLD E.		Sr.	1		ctober	12, 2009	1323 ^M
	Examin	er	4a. Facility Name (If not institut			4b. City, Town, or			4c. County of Death	
	Funeral		WASHINGTON ADV 5. Social Security Number		JAL ge (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	MONTGOMERY 9. Birthp	place (State or Foreign atry)
	Director		577-28-0913	1 🛣 M 2 🗆 F	85 Yrs.	Months Days	Hours Min.	3/22/192		ngton, DC
	and w	-	Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. City, Town or L	ocation			1	0d. Inside City Limits
	Maryla f sho	to								1 x Yes 2 □ No
	r 28a	irec	10e. Street and Number		Washingt	10f. Zip Code		10g.	. Citizen of What Cour	ntry?
	h with	alD	3100 Cherry	Road NE		200)18	Un	ited State	es
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28a-f show event, I'm Medical Event, and the modified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	If Yes, Give	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 ☑ No	spanic Origin? (Specit n, Mexican, Puerto Ric <i>Sp</i> ec <i>ity:</i>	y Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Bl a	etc.
5-0	72 hor	Completed	15. Deced	dent's Education	16a. Dec	edent's Usual Occupa	ation Juring most of working	16	b. Kind of Business/In	dustry
2121	nithin ne. han "	mple.	Elementary/Secondary (0-12		5+) `life.	DO NOT use retired;)		_	
	filed w Hygie other th		12 17. Father's Name (First, Midd	tle Last)	US Pa	rk Policer	nan 18. Mother's Name (F		overnment iden Surname)	
Maryland	d d d	To Be	Jefferson Law				Josephine			
ary	s 1 and 2 should I f Health and Men item 27 is marke other traumatic	F.	19a. Informant's Name/Relation		19b. Mail	ling Address (Street a	•		city or Town, State, Zip	Code)
ž	1 and 2 Health a tem 27 is other tra		Thomas Lawren	ce / Son	1210	Kingsbury	Drive Bow	ie, Mary	land 2072	
ore	of He		20a. Method of Disposition	on 3 Removal from State	20b. Place of Disp		Date		c. Location - City or To	
Ë	. Pag iment tant: I		4 Donation 5 Other		Fort Lin				rentwood, l	
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	1	21. Signature of Funeral Servi	7. Kurk					Homes, P.A Lle, Maryla	and 20747
-		6	23a. Part . Enjer the disease shock, or heart failure. L	, or complications that cause ist only one cause on each I	d the death. Do not er ine.	nter the mode of dying	g, such as cardiac or r	espiratory arrest	t,	Approximate Interval Between Onset and Death
1	Physician	1	Immediate Cause (Final disease or condition resulting in death)	_a	PDIOPU	LMoner	BY A	KES	1	Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	INCA	O C TI Smil			
	nu.	ia l	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	_ 1/171	RCION			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 DIA	BETES	MELLITU	10			
0,	e exec an an rial-tr	ω̈	resulting in death) Last	Due to (or as	a consequence of):					
68760,	icate be executed physician and s the burial-transit	ical		d						
9		/Med	IF FEMALE:	000 16 1100 0140000	of promoner.					
O. Box	Physician: The law requires that the death certificate this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d, Date of deliv Month	ery Day Year
σ.	s that the de ned by the a detached i		Part II. Other significant cond	ditions contributing to death	out not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to 1	he cause of death?
Records,	uires n sign Id be	d by						1 □ Yes	2 ☐ No 3 ☐ Pro	bably 4 Unknown
000	w requir s been s should	Completed						24a. Was an	24b. Were auto	opsy findings available
Be	The law te has age 2 (omo						autopsy performe	d? death?	ompletion of cause of
Vital	sician; The certificate h rector, page	Be C	25. Was case referred to med examiner?	ical			26. Place of Death		3110	
of V	hysic his ce I direc	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpat	ient 2 ☐ ER/Outpatio		4 L Nursing Home	5 Residence	ce 6 ☐ Other (Spec	fy)
	ding Ph n. After th funeral	on:	27. Manner of Death 1 Manner of Death 5 □ Pen	28a. Date of Inj ding (Month, D	ury 28b. Time ay, Year) Injury	Work		d. Describe how	injury occurred	
Division	I or Attendi after death. Director: A I in by the f.	Certification:	Z L Accident	estigation	lum. At home form o		Yes 2 □No	f Loontion (Ctro	et and Number or Rur	al Pouto Number
ΣįΣ	or A after o	ertif	4 ☐ Homicide dete	ermined 286. Flace of in building, e	jury - At home, farm, s tc. <i>(Specify)</i>	rieet, factory, office	20	City or Town,	State)	ai rioute ivalliber,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		fying Physician: To the bes cal Examiner: On the basis and manner s	of examination and/or					
	To th withir To th comp	Me	29b. Signature and title of cert	tifler / AAA	-	29c. License	e number	290	I. Date signed (Month)	Day, Year)
			1 Arak	of g IVII)		1946	05 27	0	CIOBERI	2 2009
N	, 10		30. Name and address of pers	WELLAKA 7	3257 HA	Print)	ARKWAY	GREEN	BELT MAG	24 CAMO 20HD
	Sta Registr		31. Date filed (Month, Day, Ye OCT 1 5 2009	Server 32. Regist	rar's Signature					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2009 34763

			1 - State Registrar Amended#10	a perFH FCHD,K	s Ce	ertificate of L	Death 10/	14/09 R	eg. No.		
	Physicia	212	1. Decedent's Name (First, Middle, La	ast)				Date of Deat Month	th Day	Year	3. Time of Death
	/Medic		Barbara	Miller				October 0	7	2009	7:00p M
	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or		h	4c. County		
			15188 Catoctin Mo 5. Social Security Number 6.	ountain Highway Sex 7. Age (In yrs.			ırmont If Under 24 Hrs.	8. Date of Birth		Frede 9. Birthp	lace (State or Foreign
	Funeral Director			1□ M 2X F 71	Yrs.	Months Days	Hours Min.	(Month, Day, April 2	Year)	Coun	v York
	D		Usual Residence of Decedent					Inpras 4	, 1/30		
	ırylan show	-	Maryland 10b. County	10c. Ci	ty, Town or l	ocation				10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma 8a-f	Director	Marland Fred	erick Thu	rmont	1404 771 70 1					
	vith th		10e. Street and Number			10f. Zip Code		1	0g. Citizen of V		,
	sath v	eral	15188 Catoctin Mo	untain Highway 12. Was Decedent Ever in U	S 13	. Was Decedent of H	788	Inecify Yes or No-	United	Stat e - Americ	
0	fter d	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐Yes 2 ☑ No		If Yes, specify Cuba	in, Mexican, Puerl	to Rican, etc.)		ck, White, e	
9500-612	hours after death with the Maryland tural", or items 23a or 28a-f show at Even and De notified at	ð	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:		1 □Yes 2X No	Specify:		Specify	v: W	hite
2	72 ho	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	i (Giv	edent's Usual Occup e kind of work done o	durina most of wo	rking I	16b. Kind of Bu	usiness/Inc	dustry
7	ithin ne. han "	μ	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired) -		0	II	
7	iled w Hygie ther t	ပိ	17. Father's Name (First, Middle, Las	4		Homemaker		me (First, Middle, I		Home	
yland	d be f ental red o	Be C		,				a Wechsl		,	
<u></u>	should nd Me mark imatti	ဥ	Bernard Fields 19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ling Address (Street				State, Zip	Code)
a Z	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygleine. It health and Mental Hygleine item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm "Anderl Even in a number or items."		Charles R. Miller	/ Husband	1518	88 Catocti	n Mounta	in Highw	ay,Thur	mont	MD 21788
e,	item		20a. Method of Disposition	20b. l	Place of Dist	osition (Name of ematory or other place	1		20c. Location -		
Ē	Page ment ant: If		1 ☐ Burial 2 ☑ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State ☐		Cremator		/14/09	Freder	ick,	Maryland
банттог	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Juneral Service Lice			2. Name and Address Stauffer F	ss of Facility		Α.		er fersion record
_	20 E # 9		Jode 1	wym		.621 Oposs	umtown P	ike, Fre	derick,	Mary	1and 21702
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deal y one cause on each line.	th. Do not e	nter the mode of dyir	ig, such as cardía	c or respiratory arr	est,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. BREACT	- c	ANCER					24RS
	Examiner			Due to (or as a consec	uence of):						
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consec	uence of):						
	cuted nd ransit	Examiner	that initiated events	С.							
Š.	e exe iian aı urial-t		resulting in death) Last	Due to (or as a consec	uence of):						
68/6N	e law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transit	Medical		d						_	
	ding page as		IF FEMALE:	23c. If yes, outcome of pregn	ancv				224 Da	to of dollar	
20	eath atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	al death 3	☐ Ectopic pregnanc	у			ite of delive onth	Day Year
j	requires that the death been signed by the atter hould be detached for u	Physician	1 □Yes 2 12 No 9 □ Unknown	9 Unknown							
Ţ	s that med b e deta	by Pi	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
Records,	equire en sig ould b	ed b	HYPERTENSI	ON, ANEA	N/A			1 □ Y	es 2□No	3 ☐ Prob	pably 4 Unknown
ပ္ပ	law re as be 2 sho	plet						24a. Was a	an 24b.	Were auto	psy findings available mpletion of cause of
_	The law ate has b page 2 sl	Completed						perfor	med2/	death? 1 □Yes	
VItal	Physician: this certific	Be (25. Was case referred to medical examiner?					ath (Check only or			
5	Physic this c al dire		1 Yes 2 No	Hospital: 1 Inpatient 2	· · · · · ·		4 LI Nursing I	Home 5 Resid			ý)
_	Jing F	ion	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	Wor	yat ⟨? Yes 2 □No	28d. Describe h	ow injury occur	rea	
UIVISION	Attending ir death. ector: Afte by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not	be 280 Place of Injury - At h	ome, farm, s		TES Z LINO	28f. Location (S	treet and Numb	ber or Rura	al Route Number,
<u> </u>	after after Dire	Certification: To	4 ☐ Homicide determine	building, etc. (Speci	fy)	•		City or Tow	n, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Sal C		Physician: To the best of my kn aminer: On the basis of examin							
	the Harin 24 the Fi	ledical	one)	and manner stated.	unon anu/or						
ø	Viit To 1	Σ	29b. Signature and title of certifier	(in MD		29c. Licens		2	29d. Date signe		***
ļ			00.	O'N		021	736		/ 14	100	909
1	0		30. Name and address of person who				R FRE	DERICK	, ms	2	1702
,	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		So a de d	7		,		7
				FIRST . F 18 A SEA	- 1 P						

		, roi	epartment of Health and I Certificate of Death	Mental Hygier Reg. ۱	2000 21761
Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Oay Year 3. Time of Death
/Medi	cal	George Henry Muller	45 Other Town and another of During	oct. 7,	2009 3:58a M
Exami	ner	4a. Facility Name (If not institution, give street and number) Long View Nursing Home	4b. City, Town, or Location of Death Mancheste		Carroll
Funeral	9	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Director		212-24-5023 1 M 2 F 81 Yi	'S.	12/18/192	27 MD.
/land ow at		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
a-f sh	ctor	MD. Carroll Westmi	nster		1 □ Yes 2 🙀 No
or 28 be no	Director	10e. Street and Number 225 Frock Drive, Apt. 245	10f. Zip Code	10g. (Citizen of What Country?
eath v Is 23a must	Funeral	· ·	21157	necity Yes or No-	USA 14. Race - American Indian.
and 21213-UU36 be filed within 72 hours after death with the Maryland tial Hygiene. stocker than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, White, etc. Specify: white
bours tural";	d by	3 Wildowed 4 Divorced Year or Dates:	ecedent's Usual Occupation	16h	Kind of Business/Industry
Un "na Wedic	Completed	(Specify only highest grade completed) (Give kind of work done during most of workife. DO NOT use retired)	rking	. Kind of business/industry
Maryland 21215-0036 to 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	Com	8 Lu	mber truck drive		eisterstown Lumbe
Iryiand Z should be filed and Mental Hygi marked other matic event, t	Be	17. Father's Name (First, Middle, Last) Elmer Muller		ne <i>(First, Middle, Maid</i> ed Barber	len Surname)
Maryla 2 should th and Men 7 is marke traumatic	2				y or Town, State, Zip Code) 21157
Ma Ind 2 s alth ar 27 is					Westminster, MD.
IIIMOFe, I it. Pages 1 and intment of Heali intant: if item 2 injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 20b. Place of C cemetery,	Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
timor t. Pages tment of tant: if it		4□Donation 5□Other (Specify) Carro	ll Cremation 10/	9/2009 на	ampstead, Md.
baltimo permit. Pag Department Important: I any injury o once.	V. I	21. Signature of Funeral Service Licensee M00741 Dan La Lemmer	934 S. Main St.	, Hampste	eral Home ead, Md. 21074
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	enar heade		571
Examiner	ı	Due to (r as a consequence of	the Vacanta D	harman	2001
7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	_	
ecuter and -transi	Examine	Cause (Disease or infjury that initiated events resulting in death) Last c. Due to (or as a consequence of	age		
87 bU, cate be executed obysician and the burial-transit	dical E	Due to (or as a consequence or			
56 / tificate g phys	edic	d.			
box belated the certification of the certification	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery
The COLOS, P.O. BOX of The law requires that the death certific the has been signed by the attending piage 2 should be detached for use as lage.	Physician/Med	in the past 12 months? 1 Yes 2 No	5 ☐ Other (specify)		Month Day Year
ries that the de signed by the a		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
w requires been sign	ed by			1 ☐ Yes	2 No 3 Probably 4 Unknown
VITAI MECONAS, iclan: The law requires to entificate has been signe ector, page 2 should be a	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
	Som			autopsy performed 1∐ Yes 2 🛣	? death?
Or VITA Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	ath (Check only one)	
Phy C	7: To	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at	lome 5 ☐ Residence 28d. Describe how in	6 ☐Other (Specify)
nding 1 ath. r: After	atior	1 Matural 5 □ Pending (Month, Day Year) Inji 2 □ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No		, ,
LIVISION I or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
oitai urs a erai I		29a. Certifier 12 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	and due to the cause	a(s) and manner as stated
To the Hospital or Attend within 24 hours after death. To the Funeral Director: A	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)
Vithin To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
MIL		John w. Orsholletin Mes	025443		0/7/2009
6		30. Name av address of person who completed cause of death (Item 23a) (T	D 25443 Wistminster	CW.	0/7/2009
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	A CHAMMISTER	U	
Regist		OCT 13 2009 Denun S.	parke		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D 2009 Physician October 1605 Delmar Matthews /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 29 West Washington St. Apt 405 Annapolis 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-68-8639 54 Dec 8 1954 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modest Evant increment by notified at once. 10a. State 10b. County 10c. City, Town or Location YES 2 □ No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29 West Washington St. Apt 405 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Holiday Point Elementary/Secondary (0-12) College (1-4or 5+) 11th Marine 0 Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellis Matthews Sr Mildred Gross ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Nick(Niece) 1198 Maple Ave Shady Side, Md. 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ebenezer AME Church 10-10-09 Galesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Annema Rames of Cilifons Mortuary, P.A. 21, Signature of Funeral Service Licensee 821 West St. Annapolis, Md. MC0983 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed SeuSo 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed Yes 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 🗷 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No neral Director: β filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 2121

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

1	For State Registrar	State of Mary	yland / Depa <i>Cer</i>	rtment of F	lealth and I Death	Mental Hyg	iene 201	09	34766
Physician /Medical	Decedent's Name (First, Middle, Las	st)	Moi	R		2. Date of Death		Year 09	3. Time of Death
Examiner 48	a. Facility Name (If not institution, give Anne Arundel Med			Annapol			4c. County Anne A		1
Director	Social Security Number 6. S 130-26-1782	ex 7. Age (I	n yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/12/1	^{Year)} 933	9. Birthpla Country Queen	
Ashow fishow to to to to to to to to to to to to to	Oa. State 10b. County MD Anne Ar		Oc. City, Town or Loc	eation	,			100	I. Inside City Limits 1 ☐Yes 2 ☒No
a or 28a-f sl	De. Street and Number			10f. Zip Code 21401		10	og. Citizen of V		y?
a 22 17	1. Marital Status 1 Never Married	12. Was Decedent Eve Armed Forces? 1414 Ses 2 □ No If Yes, Give Year or Dates KO		Vas Decedent of H Yes, specify Cuba □Yes 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Blac	e - Americar k, White, etc	·
Maryland 21215-0036 d 2 should be filed within 72 hours att th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Eventi To Be Completed by F	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give I life. L	ent's Usual Occup kind of work done o OO NOT use retired Sident	during most of work		16b. Kind of Bu		stry
yland yland wild be filed Mental Hygurked other attic event,	7. Father's Name (First, Middle, Last) Robert Moir				18. Mother's Nam	e (First, Middle, M			
Mary alth and M 27 is mai er traumar T	9a. Informant's Name/Relationship (Dominique Moir	Type. Print) Spouse				ral Route Number, Annapo1:			code)
Baltimore, Bernit. Pages 1 ar Papartment of Hee mportant: If item i any injury or other pages. Received to the control of	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemovar rom state	20b. Place of Dispos cemetery, crem Cossayuna		110/1	, ,,,,,	Oc. Location -	-	n, State
Baltimor permit. Pages Department of Important: If it any injury or once.	11. Signature of Funeral Service Licen	all	22. Ha	Name and Address	ss of Facility Suneral H	ome P.A.			Ave 21401
Standiner Examiner Examiner Examiner	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only immediate Cause (Final lisease or condition esulting in death) Gequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events esulting in death) Last	b. Due to (or as a co	onsequence of):	or the mode of dyin	g, such as cardiac	or respiratory arre	1/2	and cont	pproximate nterval Between Inset and Death Inset Amplication Inset Ins
BOX (Beath certication attending for use a cian/Me	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tirn 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	y		23d. Dat Moi	e of delivery	, ay Year
S, es the bed bed bed by	art II. Other significant conditions of	ontributing to death but n	ot resulting in the un	derlying cause give	en in Part I.	23e. Did tob d □ Ye	_	ribute to the 3∏ brobat	cause of death?
The lar ate has bage 2	5 Wes soon of mad by madical					24a. Was an autopsy perform 1 □Yes 2	ed?	Nere autops prior to comp leath? 	y findings available bletion of cause of
Physician ruthis certifiral director	5. Was case referred to medical examiner? 1 Yes	Hospital:		3 □ DOA Othe	ar.	th <i>(Check only one</i> ome 5 ☐ Reside		er (Specify)	
ending Feath. or: After he funers:	7. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ear) 28b. Time of Injury	28c. Injun Work M 1 🗀	yat :? Yes 2 □ No	28d. Describe how	w injury occurre	ed	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, for the funera	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	et, factory, office	()	28f. Location (Str City or Town,	eet and Numbe State)	er or Rural F	Route Number,
he Hospi in 24 hou he Funer ipletely fil	9a. Certifier (Check only one) Certifying Ph 2 ☐ Medical Exam	yslcian: To the best of m niner: On the basis of ex and manner stated	amination and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occu	, and due to the ca	ause(s) and ma te and place, a	anner as stated	ted. ne cause(s)
To the with To the Common Comm	9b. Signature and title of certifier	De	Anun	29c. License	number D W 4	29	d. Date signed	Month, De	99, 2009
H10+1 1	Name and address of person who of the last	completed cause of death 32. Registrar's	n 445 D	EFENS!	= than	HWAY An	IN APOLL	sMn	21401
State Registrar		009 Livera	A. A.	uks					

			State of Maryland / Department of Health a 1- For State Registrar #19a, per fh, 10/20/09 s1 Certificate of Death			71111	34767
am	end ite	em	1. Decedent's Name (First, Middle, Last)	2. Da	ate of Deat	h	3. Time of Death
П	Physici /Medic		TONY CAMERON MARTIN		10nth 10-14-	Day Year	03:42 AM
1	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		4c. County of Dea	ith
	,		PENINSULA REGIONAL MEDICAL CENTER Salis 5. Social Security Number 6. Sex 17. Ang. (In vrs. last hirthday) If Under 1 Year If Under		-44 Di-4b	WICO	
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Und	Min. FEI	ate of Birth Month, Day, B. 9,	Year) 9. BI	rthplace (State or Foreign ountry) VA
	σ		Usual Residence of Decedent		J. 7,	1737	
	arylan show	<u>-</u>	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2\(\) \(\) \(\)
	28a-f	Director	VA ACCOMACK HALLWOOD 10e. Street and Number 10f. Zip Code		1	0g. Citizen of What C	
	3a or		24045 BELINDA ROAD 23359		'	USA	,
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ori	rigin? (Specify Y	es or No-	14. Race - Am	
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Fu	1 □ Never Married 2 Married 1 □ Yes 2 Morried 1 □ Yes 3 □ Yes 1 □ Yes 1 □ Yes 1 □ Yes 3 □ Yes 1		i, etc.)	Black, Whi	WHITE
Maryland 21215-0036	2 hour	ted t	15. Decedent's Education 16a. Decedent's Usual Occupation			16b. Kind of Business	
215	within 72 iene. 'than "na	Completed	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	st of working			
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and	ould be fill Mental H arked otl atic ever	Be	DANDALL ENGINE MARKET	er's Name (<i>Fir</i> s PEGGY AN		Maiden Surname)	
IZ	s 1 and 2 should be f Health and Menta Item 27 is marked other traumatic ev	မ	19b. Mailing Address (Street and Number				Zip Code)
Ma	교 등 전 급		DIANA MARTIN (DAUGHTER) WIFE 24045 BELINDA ROAD				
Baltimore,	ges 1 a it of Hea if Item or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date		20c. Location - City of	Town, State
Ξ	. Pages tment of tant: If It jury or o		4 □ Donation 5 □ Other (Specify) BAPTIST CEMETERY 1	10/17/20	009 8	SAXIS, VA	
Bal	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility THORNTON FUNERA	,	- 241	PARKSLEY, 183 CHADBO	
		17650	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	s cardiac or resp	piratory arre	est,	Approximate Interval Between
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	outed ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events c. HYPERLIPIDIMIA				
Ö,	e exe ian ar ırial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical	d. VENTRICULAR FIBRILLATI	ION			
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P.O.	at the by th tache	hys	9 ☐ Unknown				
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Ö	The law requires ate has been sign bage 2 should be	Completed by	CHRONIC SWORING		125		
Rec	g & C/	ldm		— ²	24a. Was aı autops perforn	y prior to ned? death?	utopsy findings available completion of cause of
tal	ician: The lav certificate has ector, page 2.9		25. Was case referred to medical 26. Place	e of Death (Che			s 2 No
Ţ	nysici lis cer direct	To Be	examiner? Other:			ence 6 Other (Sp	ecify)
0 U	ng Ph offer th uneral	on: 1	27. Manner of Death 1 Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?		Describe ho	w injury occurred	
sio	tendi leath. tor: A	cati	2 Accident investigation M 1 Yes 2		1' (0.		
Division of Vital Records,	after of Direct of J in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. LC	City or Town	reet and Number or F n, State)	surai Houte Numper,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date are considered and manner stated.	and place, and d ath occurred at	lue to the c the time, d	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)
	orthe	Mec	29b. Signature and title of certifier 29c. License number		2	9d. Date signed (Mor	th, Day, Year)
	C 13		De108- 04052	2		10 141	0.9
	かなって	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- class	no No	we nali	09 Joney , ng 2 1804
	Sta		31. Date filed (Month, Day, Year) OCT 16 2009 School ALAL, MO 614-D Carley 32. Registrar's Signature Company Compan	W 0 404	ZVY	ive / reads	2 1804
	Registr	ar	ULI 10 2003 Blows B. 1900				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 34768 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician NEWELL 9 2009 OCTOBER 7:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LARKIN CHASE NURSING HOME BOWIE PRINCE GEORGE'S 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 10 M 2 F Hours Min. 127-26-3647 88 Director SOUTH CAROLINA AUG 19 1921 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location ir than "natural", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No PRINCE GEORGE'S BOWIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code , or Iteme 23a 20715 USA 3010 SAVOY LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No BLACK Specify. δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th HOUSE WIFE PRIVATE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other traumatic event SDRs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROSA MOULTRIE CHARLES CASWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 ROSITA HOUSE/DAUGHTER 3010 SAVOY LANE BOWIE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10-17-09 N. CHARLESTON, SC ST. PETERS CEMETERY 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STROKE /Medical Due to (or as a consequence of). Examiner FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Directo (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed -transit and resulting in death) Last Due to (or as a consequence of) burialphysician Completed by Physiclan/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 \(\sum \text{Yes} \) 2 \(\sum \text{No}\) 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 28 No 1 Yes 25 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 ☐ Yes 2 ☑ No Cther: 4 Nursing Home 5 Nesidence 6 Other (Specify) After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ∰Natural 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13,2009

CF 7

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

RICHARD FELDMAN M.D. 9500 ANNAPOLIS ROAD A-4 LANHAM, MARYLAND 20706

Date filed (Month, Day, Year)

32. Registrar's Innature

completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of person who

State of Maryland / Department of Health and Mental Hygiene 34769 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** 14, 2009 Elizabeth Julie Palmer 12:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5404 Greystone Street Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Director 579-10-2121 93 May 25, 1916 Washington, D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with neart of Health and Mental Hygiene. Anti-file may 23a or short the may 23 is marked other than "natural", or items 23a or any or other traumatic event, Its Medical Examine mat base any or other traumatic event, Its Medical Examine mat base 20815 5404 Greystone Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: <u>6</u> Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor Kissal Julie Bregand ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10808 Margate Rd. Silver Spring, MD 20901 Beth Palmer/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of Important: If its any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 10/16/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Ging Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 years Chronic Obstructive Pulmonary Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Coronary Artery Disease 10 years burial-tra Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Day 5 ☐ Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ⚠No 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1XI Natural 5 Pending Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD15928 October 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 2141 Gary M. Koritzinsky, K Street NW #407 Washington, D.C. 20037 State Registrar

State of Maryland / Department of Health and Mental Hygiene 34770 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 09 2009 10:30 pM Wanna Elaine Phillips October /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manchester Carroll 3052 Main Street 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 M 2 X MD 11 1939 70 Director 220-36-1744 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt. If other thaumatic event, If 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 TYes 2 □ No **Funeral Director** Carroll Manchester MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21102 3052 Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed by White 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Deaton Hospital Personnel Director 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wanna Elaine Fitch Harry E. Phillips ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 883 Eden Farms Circle Westminster, MD 21157 Sophie Corbin/daughter 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation, Inc 10/14/2009 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licenses Printend Address of Equility Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) umanaly /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending to the contract of the Funeral Director. as the burial-transi resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi 27. Mannef of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

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filled in by the fu 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ICW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilbu 31. Date filed (Month, Day, 32. Registrar's Signature Year!

Registrar DHMH 17 Rev 1/2001

State

P.O. Box 68760. Records, of Vital

			For State Of Ma	aryland / Depa <i>Cer</i>	rtificate of E	eaith and M Death	ептаг туд в	eg. No. 2009	34771
4	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deal Month	Day Year	3. Time of Death
	/Medic		JEAN ZACHARIAS PFEIFFER	— т	4b. City, Town, or	Location of Dooth	OCT. 9	, 2009 4c. County of Dea	4:45PM M
24	Examin	er	4a. Facility Name (If not institution, give street and number) CARRIAGE HILL OF BETHESDA		BETHESDA	Location of Death		MONTGOME	
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
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	land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
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	or 28	Director	10e. Street and Number		10f. Zip Code 20814		1	0g. Citizen of What Co	ountry?
	eath w		5215 WEST CEDAR LANE #214	Ever in U.S. 13. \	1	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Was Decedent 1 Armed Forces? 1 □ Yes 2 □ W If Yes, Give Year or Dates:	Vo	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes ※XXNo	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	te, etc. HITE
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	e filed al Hyg other vent, 1	3e C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Surname)	
ylar	ould by Mentgarked	ToE	HERBERT ZACHARIAS					R STRASBUR	
Maryland	h and l ls m		19a. Informant's Name/Relationship (Type. Print) DAVID PFEIFFER - Son	1	•			r, City or Town, State, . VA 22032	Zip Code)
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09-08073 James E. Pryor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 34772

		- For State legistrar	Cer	rtificate of	Death		R	eg. No.	~ (0411
Physicia	n/	Decedent's Name (First, Middle, Last	,				2. Date of Dea	ith Day	Year		of Death
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		4a. Facility Name (If not institution, give 11513 Hidden Brook Court		46	Beltsville	ocation of Death			ince Geo		
Funeral	-	5. Social Security Number 6. Se.	x 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs	8. Date of Bi	rth (MM/D	D/YYYY) 9	. Birthplace (State or Foreign
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or Hea		20a. Method of Disposition 1 Burial 2 \overline{X} Cremation 3		crematory or other	ion (Name of cemer er place)		Date			•	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service Licens	see	100	ame and Address	J	. B. JE				
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Virbin Virbin Comple	Medical	29b. Signature and title of certifier	and manner stated.		29c. License					(Month, Da	
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		30. Name and address of person who	completed cause of death (Iten	n 23a)							
-		and addition of person will t									
R_		Carol Allan, MD Assista	nt Medical Examiner	111 Penn S	Street, Baltimo	ore, MD 2120	71				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13, 2009 ar October 5:05 PM 50 /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner ngs wood Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, July 11, 9. Birthplace (State or Foreign Country)
Illinois Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 KF 1926 344-20-4859 July Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20816 4978 Sentinel Dr. #303 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛛 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. d 2 should be filed within ; th and Mental Hygiene. **7 is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) Journalist Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robertson Eve Morrish (unk) 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 is 6820 Wisconsin Ave #7014 Bethesda, MD 20815 Robert F. Levey/stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages the Department of Hambortant: If iter any Injury or other 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 10/15/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 🗌 Yes 2☐NO 3☐ Probably 4☐Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 4 hours at er death. 2 Accident filled is by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or within 24 hours a 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medica xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cort 29d. Date signed (Month, Day, Year) 30. Name/appeaddress of person who completed cause of death (Item 23a) (Type, Print) mollowlar Dive Odic#206 0 DCKVIII, 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 16 OCT parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 34774 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Physician Month 2009 Margaret Ε. October 10:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Director 217-18-7887 July 27, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 1 □Yes 2X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 6201 Fairfax Court Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American II Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No White Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liury or other traumatic event once. Be George Tregoning Mae Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alice Hodges / Daughter 9703 Gas House Pike Frederick, Maryland 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State October 4 ☐ Donation 5 ☐ Other (Specify) 13, 2009 Frederick, Maryland Resthaven Mem Gardens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Euneral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) metrotilie Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only offe, 1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 ER/Outpatient Certification: To ō 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funera Director: After t Natural 2 ☐ Accident 5 Pending investigation 1 🗌 Yes 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

10

Nineth Street Frederick, Maryland 21701

300 W.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Kaufmann, M.D.

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 34775 1. Decedent's Name (First, Middle, Last) 2. Date of Death Patricia Marks Stewart **Physician** 8:55 12, 2009 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number 072-18-6089 **Funeral** 1 ☐ M 2 🕱 F 1925 New York 30, 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Modest Evanding or ust by notified at 1 XYes 2 No Maryland Montgomery Gaithersburg Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20878 United States 819 Jonker Court Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2K No If Yes, Give Specify: ş 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Food and Drug 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Administration Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anastasia Higgins Thomas Marks ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 819 Jonker Court, Gaithersburg, MD 20878 Merrick Wood Stewart (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other page 12 Metropolitan Crematory 20c. Location - City or Town, State 20a. Method of Disposition Oct. 16, 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility DeVol Funeral Home, 21. Sign ture of Funeral Service 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 art 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Else underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, ettending physician or use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 🖾 No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Multiorgan Failure certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗓 No 1 ☐Yes 2 ☐ No Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 X Natural nours after death.

neral Director: Ailed in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi To the within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 13, 2009 HUBY ~ D0062562 Manan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Madhavi Hubbly, M.D., 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar 16 2009

Physician

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Day 2009 11:20 A M Grace Ann Sheffield 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔀 F New York 79 Yrs. 1930 April 6, 10c. City, Town or Location 10b. County 10d. Inside City Limits Frederick Frederick 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 21703 USA 6810 Farmbrook Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2X No Specify 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Administrative assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Lewis Spencer O. Geasey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6816 Dam Number 4 Road, Sharpsburg, Maryland 21782 Joyce Sheets - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 10-15-2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home Sharon Camiele 1621 Opossumtown Pike, Frederick, Maryland 21702 line 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INTRA CICANIAL HEMORRHAGE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD56941

certificate

this

eral Director: A filled in by the fi

Be

Certification: To

Medical

State

Registrar

OHIT

31. Date filed (Month, Day,

400 W 7th St

Frederick, Hd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2009 ▶

MD

32. Registrar's Signature

KAPOOR

Year)

		Registrar	State of Maryla	Cer	tificate of L	Death	F	Reg. No.	
Physicia /Medica	n al	Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give stress)	reet and number)	5+	ans bu		2. Date of Dea	Day	Year 12:42 P
Examine	er	The Johns Hopkins Hos			Baltimore				
ineral rector		5. Social Security Number 6. Sex 220-50-1751	7. Age (In y	9 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		, Year) 1949	Birthplace (State or Foreig Country) MARYLAND
		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limit
a-f sho	tor	MARYLAND HARFOR		,	HAVRE D	E GRACE			1 X Yes 2 □ N
or 28	Director	10e. Street and Number			10f. Zip-Code	04.000		10g. Citizen of W	
ns 23a must b	Funeral	626 FOUNTAIN ST	2. Was Decedent Ever in	n U.S. 13. \	Nas Decedent of Hi f Yes, specify Cuba	21078 Ispanic Origin? (Specify Yes or No-	14. Race	D STATES American Indian,
al", or iter Examiner	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba I ☐ Yes 2 X No	n, Mexican, Pue Specify:	rto Rican, etc.)	Specify	k, White, etc. : AFRICAN AMERICAN
"natur dical l	leted	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual Occup kind of work done o OO NOT use retired	during most of w	orking	16b. Kind of Bu	usiness/Industry
r than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	me. L	CUSTODIA			PRIV	ATE SCHOOL
d oth	To Be C	17. Father's Name (First, Middle, Last) CHARLES STANSBURY					ame (First, Middle,		re)
is ma rauma		19a. Informant's Name/Relationship (Type DEBRA LESTER / SIS		T.	ng Address (Street				
item 27 other to	1	20a. Method of Disposition		b. Place of Dispo	sition (Name of	i	Date		MD 21078 City or Town, State
		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		natory or other plac UNITED		0/22/09	HAVRE 1	DE GRACE, MD
Important: If any injury or once,		21. Signature of Funeral Service Licensee	" " ()	16 m	LISA SC 552 LEW	OTT FUNI	ERAL HOME	P.A.	CE, MD 21078
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one		eath. Do not ent					Approximate Interval Between Onset and Death
sician and sician and and and and and and and and and a	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsace or injury that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con Due to (or as a con	sequence of):					
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pre 1	Fetal death 3	Ectopic pregnancy	У		23d. Dat Mo	e of delivery nth Day Year
signed by	þ	Part II. Other significant conditions cont	ributing to death but not	t resulting in the t	underlying cause gi	ven in Part I.	23e. Did to	7	ribute to the cause of death?
te has been bage 2 shou	Completed						24a. Was a autop perfo	rmed?	Were autopsy findings availa prior to completion of cause death? 1 🗌 Yes 2 🔲 No
artifica actor, g	Be	25. Was case referred to medical examiner?	nonital: a		Oth		eath (Check only o		
this or	은	1 Yes 2 No	ospital: Impatient 28a. Date of Injury	2 ER/Outpatien 28b. Time o		4 🗆 Nursing	Home 5 Resid	lence 6 Oth	
Director: After in by the fune	Certification:	Thatural 5 ☐ Pending investigation Could not be determined	(Month, Day Year) 28e. Place of injury - A building, etc. (Spe	at home, farm, str	M 1 🗆	ć? Yes 2 □ No	28f. Location (City or Tow		er or Rural Route Number,
Etely filled	Medical C		cian: To the best of my ler: On the basis of examend manner stated.						anner as stated. and due to the cause(s)
To the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	d (Month, Day, Year)
		1 Stelo	5		RE	5-000		CETUBE	TR 14, 2009
	Ī	30. Name and address of person who col	moleted cause of death	(Item 23a) (Type	Drint)				•
		BRUCE SA	BATH	(item zoa) (type,	riiit)	600	North Wa	Ifo St Da	Itimore, MD, 212

DHMH 17 Rev 1/2001

			For State Registrar		State o	f Marylaı	nd / Depa <i>Cel</i>	artme rtifica	nt of F te of I	lealth D <i>eath</i>	and M	ental Hy	giene Reg. No	2009	347	78
			1. Decedent's Name (First, Midd	fle, Last)	-							2. Date of De Month		v Voor	3. Time of Dea	ath
	Physici /Medio		Dorothy Jeann	ette	Schra	uder						Octobe	r S	2009 2009	11:40g	D W
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			Transitions H	ealtl	h Care				ykes					Carro		
	Funeral Director		5. Social Security Number 220-05-9404	6. Sex 1 □	M 2√F		s. last birthday) 90 Yrs.	If Und Month	er 1 Year Days	If Unde Hours	Min.	8. Date of Bir (Month, Da June 1	th 17. Ye <i>ar</i> 19. 19	919 9. Bir	thplace (State or Fountry) MD	reign
	pu »		Usual Residence of Decedent 10a. State 10b. Count	.,		100 0	ity, Town or Lo	cation							10d. Inside City Li	imite
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	3a or	Funeral Director	10e. Street and Number 7309 Second A	venue	е				21784				10g. Ci	USA	outiny:	
	death	ner	11. Maritai Status	1	2. Was Dece	edent Ever in U	J.S. 13.	Was Dec	edent of H	ispanic O	rigin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Amo		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examples must be rectified at		1 ☐ Never Married 2 ☐ Ma X☐ Widowed 4 ☐ Divorce		Armed Fo 1 ∐Yes If Yes, Giv Year or D	2 XNo ve		_ `	2 ∏ ⊼ o	Specify		Alcan, etc.)		Black, Whit	e, etc. Nhite	
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215	tthin 7 ne. nan "r	Completed by	(Specify only high Elementary/Secondary (0-12)	est grade	Completed) College (1	-4or 5+)	life.	DO NOT	use retired	d)	ist of Workii	ig	Or.70	n Home		
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Maryland	d be fill ental H ced ott	o Be	17. Father's Name (First, Middle Felix Bush	, Last)								(First, Middle, Schrad		i Surname)		
IZ.	shouls nd M mari	ြို	19a. Informant's Name/Relation	ship (Typ	e. Print)		19b. Mailir	ng Addre	ss (Street					or Town, State,	Zip Code)	
	i and 2: Health a em 27 is		Linda Auerback		-		2045	Dor	Ave	nue	West	ninster	, M	2115	7	
ē,	s 1 a of He item othe		20a. Method of Disposition			20b.	Place of Dispo	sition (N	ame of	e)	D	ate	20c. L	ocation - City or	Town, State	
Ē	Page nent c ant: If ury or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (emoval from		odlawn			:	10/1	3/2009	Woo	dlawn, N	ND	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra once.		21. Signature of Folheral Service Licensee Printegraphic Licensee and Charles Westington Road Westing											21157		
			23a. Part 1. Enter the disease, of	or complic	ations that c	aused the dea				-				ccry . is	Approximate Interval Between	
	Physician	3	shock, or heart failure. Lis Immediate Cause (Final	st only one	e cause on e	ach line.	F	2.							Onset and Deal	th
	/Medical		disease or condition resulting in death)	a.	Due to (or as a conse	quence of):						-		leave	
7	Examiner			h												
	D ≓	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Jï	Due to	or as a conse	quence of):									
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.												
8760,	cate be executed physician and the burial-transit	E	resulting in death, cast	L	Due to	or as a conse	quence or):									
87		dical		d.												
9 X	eath certifii attending p for use as	Physician/Me	iF FEMALE:	23	c. If yes, out	come of pregr	nancy							23d. Date of de	livery	
Box	death a atter	ciar	23b. Was decedent pregnant in the past 12 months?		1 🗌 Live I	oirth 2 🗀 Fet nant at time of	al death 3		pregnanc specify)	у				Month	Day Year	r
P.O.	t the de by the ached	hysi	9 ☐ Unknown		9 Unkn	own						T.				
Vital Records, F	Physician: The law requires that the death certificate this certificate has been signed by the attending ral director, page 2 should be detached for use as	by	Part II. Other significant condit	ions cont	tributing to de	eath but not re	sulting in the u	nderlying	cause giv	en in Part	t I.	23e. Did t		/	o the cause of death	
Ö	v requir been s should	ete										24a. Was	an	24h Were a	utopsy findings avai	ilable
Re	: The fav	Completed										auto perfo	psy prmed2	prior to death?	completion of caus	e of
tal	i clan: The certificate ector, pag	au	25. Was case referred to medic	al						26 Plac	re of Death	1 ☐Yes (Check only o	2 Ø N₁	0 1 ∐Ye	s 2 No	
>	ysician; is certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Ho	ospital:	Inpatient 2	☐ ER/Outpatie	nt 3□I	OOA Oth	or.				6 ☐Other (Sp	ecify)	
n of	ing Ph	ion: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pend		28a. Date	•	28b. Time o Injury	f	28c. injur Worl	y at k?		28d. Describe				
Sio	ttend death stor: /	icati	2 Accident inves 3 Suicide 6 Could	tigation I not be	ORe Diese	of lainer Ath	ome form str	M		Yes 2		Of Location (Ctroot o	nd Number of E	ural Route Number	
Division	s after or Ail Direct all Direct by all Direct by all by	Certification:	4 ☐ Homicide deter	mined	buildi	ng, etc. (Spec	nome, farm, str ify)	eet, tacto	ory, office		ľ	City or To			urai noute Number,	,
	To the Hospital or Attending Physic within 24 hours after deadt. To the Funeral Director: After this completely filled in by the funeral director.	Medical (29a. Certifier 1 Certify (Check only 2 Medical	ing Phys i Examin	er: On the b	best of my kr asis of examir ner stated.	nowledge, deat nation and/or in	h occurre vestigati	ed at the tilon, in my c	me, date pinion, d	and place, eath occurr	and due to the ed at the time,	cause(date ar	s) and manner and place, and du	as stated. e to the cause(s)	
	To the within complete the comp	Me	29b. Signature and title of certifi	er				2	9c. Licens	e number	r		29d. D	ate signed (Mon	th, Day, Year)	
	WIL		1/1th_4	h	· M.	0			000	581	37		10	112 69		
	6		30. Name and address of perso	n who cor	npleted caus	e of death (Ite	em 23a) (Type,	Print)					1	+ = +=/		_
			Willow Kus	2	95	Stone	(AL	2	St 3	97	w	estonin	ste	- MO	21157	/
	Sta Registr		31. Date filed (Month, Day, Year	132		egistrar's Sign	ature	lan.	41							

			State of Sta	of Maryland / Dep Ce	partment of H e <i>rtificate of D</i>	lealth and N <i>leath</i>	ental Hygie Rec	ene 2009	34779
	Dhysisis	~/	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia Medic	al	Judy Anne Singleton				October	10,2009 Year	2055 ™
	Examin	er					4c. County of Deat		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday,		If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
ı	Director		213-64-0933 1 M 2 XF	56 Yrs.	IVIOITIIS Days	Hours Min.	08/11/19	53 Vir	ginia
	and show l at	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	-			10d. Inside City Limits
	Maryli 28a-f otifiec	irect	MD Anne Arundel	Odent	ton				1 🗆 Yes 2 No
	th the	al D	10e. Street and Number		10f. Zip Code		109	g. Citizen of What Co	untry?
	ath wi	Funeral Director	687 Old Waugh Chapel Ro	edent Ever in U.S. 13	. Was Decedent of His		cify Yes or No-	USA 14. Race - Ame	rican Indian
036	rs after de ıral", or ite Examine	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 1 Ye	orces? 2X No ve X	If Yes, specify Cubar 1 ☐ Yes 2 🛛 No	n, Mexican, Puerto	Rican, etc.)	Black, White	
2-0	2 hou "natu	plet	15. Decedent's Education (Specify only highest grade completed) I (Give	edent's Usual Occupa e kind of work done d	ation uring most of work	ng 16	6b. Kind of Business	Industry
121	ithin 7 ene. r than the Me	Completed	Elementary/Seconday (0-12) College (*	l-4 or 5+) Bus	DO NOT use retired) Attendant			Bus Compa	ny
Maryland 21215-0036	l be filed w lental Hygi rked othe lic event,	To Be (17. Father's Name (First, Middle, Last) Harry Hensley			18. Mother's Name	e (First, Middle, Mai Morris	den Surname)	
, Mary	d 2 should salth and M n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Ginger Beardan Daugh	ter 483	lling Address (Street a	nd Number or Rura r Lane Ga	al Route Number, Ci	ity or Town, State, Zip MD 21054	Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial ※XX Cremation 3 ☐ Removal fron 4 ☐ Donation 5 ☐ Other (Specify)		position (Name of ematory or other place Cremator	9) ! .		oc. Location - City or len Burni	
Balt	permit. Departr Import any inji		21. Signature of Funeral Service License		22. Name and Addres Hardesty F		ome P.A.	851 Annap Gambrills	olis ₂ R8ad MD 21854
	Hrysician,	8	23a. Part 1. Enter the disease, or complications that shock, or hear failure. List only one cause on e Immediate Cause (Final disease or condition	ach line.	nter the mode of dying	1 1	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to Sequentially list conditions, b.	(or as a consequence of):		Sys.4			
	executed an and rial-transit	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	(or as a consequence of):	r.				
09/	cate be executed physician and the burial-transit	edical E	resulting in death) Last Due to	(or as a consequence of):					
200	ertifical ding ph	/Med	IF FEMALE:	tcome of pregnancy					
. Box	ne death ce the attenc	Physician/M	in the past 12 months?	Birth 2 Fetal death 3 gnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date of del Month	ivery Day Year
IS, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate bewithing the formus after death certificate has been signed by the attending physicis to the tuneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	þ	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	en in Part I.		cco use contribute to	the cause of death?
Records,	ne law requ e has beer age 2 shou	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
<u>a</u>	ian: Ti rtifical ctor, p	BeC	25. Was case referred to medical examiner?		26. Pla	ce of Death (Check		No 1 ⊔ Yes	2 🗆 No
Vital	Physic this ce al direc	မ	1 ☐ Yes 2 ☐ No	Inpatient 2 ER/Outpatie		4 ☐ Nursing Ho		ce 6 Other (Spec	ify)
on of	tending F leath. tor: After i the funera	Certificate:	2 Accident Investigation	nth, Day, Year) injury	M 1 □	at Yes 2 □ No	28d. Describe how	injury occurred	
DIVISION	ital or At urs after o ral Direct lled in by		4 ☐ Homicide determined 28e. Placi build	e of Injury - At home, farm, sing, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Numb City or Town, State)				
	the Host thin 24 ho the Fune mpleted fi	Medical	29a. Certifier (Check conly one) 3 Certifying Physician: To the back only one) 3 Certifying Nurse Practioners	sis of examination and/or inve	estigation, in my opinion, death occurred at the	n, death occurred at time, date and plac	the time, date and pe, and due to the ca	place, and due to the ouse(s) and manner as	cause(s) and manner stated. stated.
	7 vij		29b. Signafule and title of condition	an		6376	29d	Date signed (Month	(Day, Year)
(AH		30. Name and digress of person who completed cau	2001 Medi	call kwe	1 Anna	polin	MD 2	1401
	Stat Registra		31. Date fill (Month, Day, Year) 0CT 14 2009 32. F	Registrar's Signature	park		J		

			For AMEND#16a per FH State of Mary	yland / L	Department of Ho Certificate of D	eaith and Ment Death	ai riygieii	2009	34780
ń			Registrar AACO HFALIH DFPT. 10/14/09 (1. Decedent's Name (First, Middle, Last)	<u>CMH</u>	Octimente of E	2. Da	Reg. N		3. Time of Death
	Physicia /Medic		Constance Smi	th			onth D Citober	ay 10 th Year 2009	5:20 PM
and of	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			c. County of Death	Δ. Λ
4			5. Social Security Number 6. Sex 7. Age (1		0101	If Under 24 Hrs. 8. Da		Anne Au	undel
ı	Funeral Director		5. Social Security Number 6. Sex 7. Age (I 213-52-4161 1 M 2X F	in yrs. last birt	Yrs. Months Days	Hours Min. Jun	ite of Birth Conth, Day Yea C 28 I	943 Mary	ace (State or Foreign Land
	ס		Usual Residence of Decedent						
	arylar show	<u>ا</u> ۾	Maryland Anne Arundel	0c. City, Town	or Location Burnie			10	d. Inside City Limits 1 □Yes 2K No
	the Mi	Director	10e. Street and Number	01011	10f. Zip Code		100.0	Citizen of What Count	
	3a or	Ö	8120 Turn Loop Rd.		2106	51	109. 0	USA	· y ·
	death	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of His If Yes, specify Cuban		es or No-	14. Race - America	
36	or Ite	by Fu	1 Never Married 2 Married 1 Yes 2 No		1 □Yes 2 □No	Specify:	610.)	Black, White, e	
00	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examinat must be notified at	ed b	3 ☐ Widowed 4 XDivorced Year or Dates:	16a	Decedent's Usual Occupa	tion	16b	Specify: Bla Kind of Business/Ind	
215	hin 72 9. an "na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		(Give kind of work done du life. DO NOT use retired)	uring most of working		cial Sec	
7	ed wit ygien er tha	Con	12th lyr	<u></u>	Balance Cle			ministra	tion
and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Phillip I. White			18. Mother's Name <i>(First</i> Myrtle Ha		n Surname)	
Ë	thould nd Me mark matic	은	19a. Informant's Name/Relationship (Type. Print)	19b	Mailing Address (Street a			or Town State Zin	Code)
S	nd 2 salth ar 27 is r trau		Linda Lucienne(Daughter)		17 Yale Ave				
ore,	of Her		20a. Method of Disposition		Disposition (Name of y, crematory or other place			Location - City or Tov	vn, State
Ĕ	Page Iment tant: It		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		enter Hill	10-19-		verna Pa	rk, Md.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee			of & collisions M			1
	202 40		23a. Part 1. Enter the disease, or complications that caused the			St. Annap			Approximate
8	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final				,,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Metast Due to (or as a co		Lung Cance	r			
	Examiner		Sequentially list conditions b.						
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	onsequence o	of):				
<u> </u>	execu n and al-trar	Examiner	that initiated events c	onsequence o	of):				
68760,	ficate be executed physician and s the burial-transit	edical	d						
	ertifica ling ph e as th	Med	IF FEMALE:						
Box	leath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death	3 Ectopic pregnancy 5 Other (specify)		7.4	23d. Date of deliver Month	y Day Year
o.	v requires that the dibeen signed by the should be detached	ysic	1 Yes 2 No 9 Unknown	le oi deatii	5 D Other (specify)				
о, С	s that gned t	by P	Part II. Other significant conditions contributing to death but n	ot resulting in	the underlying cause giver	n in Part I. 23	e. Did tobacco	use contribute to the	e cause of death?
Ö	equire sen sig ould b						1 Yes	2 🕅 (vio 3 🗆 Proba	ably 4 Unknown
ō		a)							
3ecol	e law has b	힏				24	ta. Was an	prior to con	sy findings available apletion of cause of
al Recor	The lay ate has page 2	Completed	05 Western for the second			1	ta. Was an autopsy performed? □Yes 2 🎞	prior to con death?	pletion of cause of
Vital Recor	ician: certific ector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No Hospital: 1 ☐ Innatient	2∏ FB/Out	Othor	26. Place of Death (Che	4a. Was an autopsy performed? □Yes 2 □ ck onl one)	prior to con death? do 1 □Yes	npletion of cause of 2 □No
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			State of Maryland / Depar State of Maryland / Depar State of Maryland / Depar	tment of Health and M ificate of Death		ene 2009	34781
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
4	Physici /Medic		Johnnie Bea Slay		October	8 2009	2201 ^M
	Examin	er		b. City, Town, or Location of Death		4c. County of Death	d . 1
_	Funeral		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Aru	
	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	1950 Miss	ace (State or Foreign
	pu ,		Usual Residence of Decedent				
	arylar shov	<u>۱</u>	10a. State 10b. County 10c. City, Town or Loca			10	0d. Inside City Limits 1 ☐ Yes 2√☐ No
	the M	Directo	Maryland Anne Arundel Annapoli 10e. Street and Number	S 10f. Zip Code	100	. Citizen of What Coun	**
	aa or		221 South Cherry Grove Ave	21401	log	USA	
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Items 23a or 28a-f show event, I'm M. dical Evaluan man that the rectified at	Funeral		as Decedent of Hispanic Origin? (Spires, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
စ္	or Ite		1 TvNever Married 2 ☐ Married 1 ☐ Yes 2 TvNo	es, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
8	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				ack
15-	n 72 ł	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupation nd of work done during most of worki NOT use retired)	ing 16	b. Kind of Business/Inc	ustry
12	withii iene. than	ошр	Elementary/Secondary (0-12) College (1-4or 5+)	sultant		IBM	
Maryland 21215-0036	s 1 and 2 should be filed of the filed of the filed 1 street 27 is marked other other traumatic event, it	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	iden Surname)	
<u>la</u>	should be fi and Mental I s marked of sumatic ever	To E	John Slay Jr	Essie	Donald		
ar)	2 sho l and l is ma			Address (Street and Number or Rura			,
	and sealth m 27			outh Cherry Gr			·
Baltimore,	D		1 Buriai 2 La Cremation 3 Li Hemoval from State 1	tory`or other place)		c. Location - City or To	,
Ħ	permit, Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) Metro Cr			altimore,	Md.
Ba	permit, Pag Department Important: I any Injury c			Name Ræaæs of&cil S ons 1 West St. Ann			1
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter				Approximate Interval Between
-	Physician	5 24	shock, or heart failure. List only one cause on each line. Immediate Cause (Final		6 040	03	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	oricinoma of	breas	7.	
	Examiner						
	p #	ner	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury				
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8760,	icate be executed physician and the burial-transit		Due to (or as a consequence or).				
	fficate g phys s the	edical	d				
Box	w requires that the death certifice been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
B	death	sicia	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ C	ctopic pregnancy Other (specify)		Month	Day Year
т. О	requires that the seen signed by th hould be detache	Phys	9 LI UNKNOWA				
S,	res th signed	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		co use contribute to th	
Records,	requi	Completed	acure revial fartire		1 Yes	2√2 No 3 Prob	ably 4 Unknown
ě	elaw hasb je 2 sł	ם			24a. Was an autopsy performed	prior to con	sy findings available apletion of cause of
VItal	n: Th ificate or, pag		OS Was asso referred to madical		1 □Yes 2 4		2 □ No
5	s certi	Be	25. Was case referred to medical examiner? 127 Yes 2 □ No Hospital: 1 ☐ Inpatient 2 □ ER/Outpatient	26. Place of Death		о Понь и со и и	
0	g Phy er this eral d	Certification: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how	e 6 ☐Other (Specify injury occurred)
DIVISION	arth. r: Aft	atio	1 Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 □Yes 2 □ No			
<u> </u>	r Atte ter de recto	ti liic	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural	Route Number,
5	ital o Insaff ral Di					·	
	To the Hospital or Attending Physician: The law within 24 Junus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant and manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of/certifier	29c. License number	29d.	Date signed (Month, L	Pav. Year)
	FSFÓ		And Commo	258510		10/08/0	
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri			(/ -	4
0	CH		Stophen Olexo ArAMI				
	Sta	_	31. Date filed (Month, Day, Year) OCT 14 2009 32. Registrar's Signature				
	Registra	ar	OCT 14 2009 Jeneur B. Jo	ares .			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 34782

		1- For State Registrar		tificate d	of Death			Reg. No.	0 7 0 7 1 0
Physici ledical Exami		Decedent's Name (First, Middle,Later CHARLES SYLVEST)	ER SMITH, SR.		F. 6: 7		2. Date of Dea Month October	Day Year 10, 2009	3. Time of Death 1626 hrs
		Facility Name (if not institution, give street and number) Prince George's Hospital Center			4b. City, Town, or Location of Death Cheverly		n	4c. County of Di Prince Geo	
Funeral		5. Social Security Number 6. S		st birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of B	irth(MM/DD/YYYY) 9.	
Director		213-42-6986	м 2_F 66	Y	Months Days	Hours Mir	08-25	-1943	oreign Country) MD
*		Usual Residence of Decedent							I dod beside City Limite
ow any		10a. State 10b. County		Town or Loc	ation				10d. Inside City Limits 1 V Yes 2 No
Aaryland 28a-f show Latonce	ctor	Maryland Prince (eorge's Lar	go	10f. Zip Code			10g. Citizen of What (Λ
ith the Maryland 23a or 28a-f she	Director	500 N. Harry S. T	ruman Dr., #11	5	20774			USA	
with t ns 23a be not		11. Marital Status	12. Was Decedent Ever in U.S		/as Decedent of His				merican Indian, Black,
r death or ite	Funeral	1 Never Married 2 Married	1 Yes 2 X No	"	Yes, specify Cuban.		o Rican, etc.)	White, et	
hours afte 'natural'', Examiner	by	3 Widowed 4 \(\) Divorce 15. Decedent's Education (Specify of	If Yes, Give Year or Dates:	16a Decede	Yes 2 X No		work done	Specify: B1	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		most of working life.				, , , , , , , , , , , , , , , , , , , ,
1036 vithin 72 ene. er than Vedical	mpl	9th		Cus	stodial Su	-			eo. County
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygies. 27 is marked other than "natural", or items 23a or 28a-f she arrise event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Las Raymond Smith)			8.Mother's Nam		Maiden Surname)	
212 ould be Menta marko c even	To Be	19a. Informant's Name/Relationship (Гуре, Print)	19b. Maili	ng Address (Stree			ımber, City or Town, S	State, Zip Code)
MD d 2 sho lth and n 27 is rumati		Yvonne M. Turner/						1ton, MD 2	
Baltimore, MD 21215-0036 Permit Pages and should be filed within 72 Personnel program of Health and Marell Hygiene. Important: If litera 77 is marked other than 'nijury or other traumatic event, the Medical		20a. Method of Disposition 1 XX Burial 2 Cremation 3		lace of Disportenatory or o	osition (Name of cen other place)	netery,	Date	20c. Location - Cit	y or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If itei		4 Donation 5 Other Specify	Line		lem. Cemet		-17-09	SUitland,	Maryland
Ball permit Depar Impor		21. Signature of Funeral Service Lice May Hedoma	M MU1374		Name and Address	•	1 DA A.,	o Cui+1a	and, MD 20746
Physician		23a. Part I. Enter the disease, or com	olications that caused the death.	Do not enter	the mode of dying,	such as cardiac	or respiratory ar	rest, shock, or heart	Approximate Interval
failure. List only one cause on each line. Immediate Cause (Final disease a. Exsanguination from vascular shunt for dialysis for chronic renal failure						Between Onset and Death			
*aiiiiioi		or condition resulting in death)	Due to (or as a consequence of):					
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):							
cecuted									
ज्ञ ह	n/Medical	UNPENDED	AMENDED						
8760, tificate be exning physiciar as the burial	√/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	F	etal death 3	Ectopic pregn	ancy	23d. Date of del Month	livery Day Year
Box 68 le death certi the attendin ted for use an	sicia	past 12 months?	4 Pregnant at time of dea	oth	Other (Specify)		laricy	World	buy roa
Box he death c	Phys	1 Yes 2 No 9 Unknow	9 DIIKIIOWII			ivon in Deat I	220 Did	tohacco uso contribut	to to the cause of death?
P.O. res that the signed by be detach	þ	Hypertension Diabetes Prostate Cancer					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown		
ds, require oeen si ould b	Completed						24a. Was		re autopsy findings available
Records, The law require	du				-			ormed? dea	
tal Recian: The certificate ector, page		25. Was case referred to medical			26.Place	of Death (Check		2 140 1	Yes 2 No
Vital hysician: this certi	To Be	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other Nursi	ing Home 5	Residence 6	Other:
Division of Vital Records, P.O. Box 6 the Hospital or Attending Physician: The law requires that the death cer hin 24 hours after deep. After this certificate has been signed by the attendinpletely filled in by the funeral director, page 2 should be detached for use:	L:uo	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: Day, Year)	28b. Time o		ry at Work?		how injury occurred ated from vascul	ar shunt
Division tal or Attendi rs after death.	cati	2 Accident 5 Pending Investigation	10-440-0000	1515 hrs		'es 2 ✓ No	28f Location	(Street and Number of	or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could no determine	be		cot, lactory, cilico b	unung, oto.			Apt. 115, Upper Marlboro,
D To the Hospital Within 24 hours To the Funeral		29a. Certifier (Check only 1 Certifying Physic	ian: To the best of my knowledg	e, death occ					
To the Hos within 24 h To the Fur completely	Medical		r:On the basis of examination ar and manner stated.	nd/or investig			at the time, date		
	Σ	29b. Signature and/title of certifier	-6/// 1/ 1080	r	29c. Licens			29d. Date signed October 11, 2	(Month, Day, Year)
		30. Name and address of person who	completed cause of dooth (Hom	23a)		***		000000111,2	-000
R 5			ssistant Medical Examin		Penn Street, B	altimore, MD	21201		ļ
S		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ELEN.				-	
Regis	trar	OCT 1 5 2009	Kreen B. All	urcan					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JEROL YN 10:40 P M 13 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PGI crescent If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 2,1949 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min. 1 M 2 A F Months Days 60 577-70-1950 Director Galveston. Texas Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinst must be notified at Md Prince George's Capital Heights 1⊠Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 732 Mentor Avenue 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Data Entry Operator 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold King Mitchell Ruth Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winfield Smith/Husband 732 Mentor Avenue, Capital Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory 10-16-2009 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland 21. Signature of Fundal Bervice Licensee 22. Name and Address of Facility Jonnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any warfing to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a gunswouvings off Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Be 1 ☐ Yes V ☐ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After th funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Dea 28b. Time of 28c. Injury at/ Work? 28d. Describe how injury occurred 1 Natura 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician: 10 the best of my knowledge, deam occurred at the time, date and place, and due to the cades(s) and manner. So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 0064208 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20737-1058 4409 East-West Highway, Riverdale, Maryland Saadia Husian, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 1 6 2009 D. park

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 34784 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Month Year **Physician** Scott 9:50 AM TAYLOR Louise 2009 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Peninsula Salisbury Wicomico Regional Center Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
VIRGINIA 8. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 20XF 87 224-28-6470 Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours eftar deeth with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental hygiene. 7 is marked other than "naturs!", or frems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Pocomoke Funeral Director Maryland Worcester 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21851 Street U.S.A. 405 Maple 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White Completed by Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic tomemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Doshia GlAdding OSCAR TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hter 405 maple 5t., Pocomoke, MD

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Date 20c. Lo Department of Heelth a important: If item 27 is any injury or other trai 21851 Alice Scott HOWARd /Daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State PARKSley, VA PARKSley Cemetery 10.12.09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams Funeral Home 250 46 Parksley Rd, P.o. Box 1, Parksley, VA

23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 23421 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Syeary Examiner Due to (or as a consequence of) Physician/Medical Examiner es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, attending physiclen for usa es the buria Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? paga 2 s 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this i Director: After this ed in by the funeral of 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funersi Director: At completely filled in by tha fu investigation 2 ☐ Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 100 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature end title of certifier ē DO51359 1017109

DHMH 16 Rav 6/95

State Registrar 1415 S. Division Street Ste. B Salisbury, MD

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

Usha Natesan MD
31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#'s17.18.PerFHPGC10-15-69ctificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0842 M TRIPLETT LAWRENCE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SUBURBAS Montgomery Bethesda 8. Date of Birth (Month, Day, 19ar) 1939 9. Birthplace (State or Forei Country) 18, 1939 Washington, DC If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ₩ M 2 □ F 70 Yrs. 579-52-5143 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" ~-." any Injury or other traumatic event. 10a State 10h County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director DC Washington, DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20011 15 McDonald Place, NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 □ Never Married 2 N Married **Black** 1 ☐ Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Supervisor vears Unk. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Lee Reginald Triplett ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 McDonald Place, NE, Washington, DC 20011 Barbara Triplett/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-15-2009 Triangle, Virginia Quantico National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician A THLEROSCHEROTIC CARDIOVASCULAR DISEASE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inJury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) his certificate has been signed by the director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this y filled in by the funeral di Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2600 OLD George & was Ro Bettesda MA 2084 PREDERICIC HALEN MO 31. Date filed (Month, Day, Year 0CT 1 5 2009 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat Month Day Year **Physician** 9,2009 OCTOBER 4:50A JAMIE VELASCO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1⊠M 2□F Director 57 5, 1952 Virginia 215-62-4583 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director Maryland Frederick Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 United States 912 Leafy Hollow Circle 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Officer 5+ U. S. Secret Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ James Velasco Anna Lucille Baber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie D. Velasco / Wife 912 Leafy Hollow Circle, Mt. Airy, Maryland 21771 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2009 Pine Grove Cemetery Mt. Airy, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ventricular Immediate Cause (Final tackycardia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown ئے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manger of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death | Director: / id in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide e Funeral Distriction of the Funeral Distriction of the Funeral Distriction of the Funeral Distriction of the Distriction of th 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ariuova 09 MDD65443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Dr. Elena Iarikoua

31. Date filed (Month. Da

4 2009 Registrar's Signature

400 West 7th Street, Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34787 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Katherine Sipes Valianti 2:22 19 2009 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 □ M 2 StF 89 Maryland May 10, 1920 Director 213-18-9293 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Westminster Director Carroll Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 21157 807 David Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept. of Agriculture Assistant Manager 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Trite ပ္ Clarence Sipes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 303 Queen Anne Cr., Westminster, MD 21157 of Health a Joan Knott/Daughter item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or conce. 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Westminster, Maryland 10/10/2009 St. John Cemetery 4 Donation 5 Other (Specify) 22. NPrejetter Formerval Home and Chapel, P.A. 21. Signature of Funeral Service License - Jervi 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Neute disease or condition resulting in death) /Medical Due to (or as a consequence of): Due to Tras a conserve Examiner Sequentially list conditions, if only loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to or as a consequence of): remen Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TIME Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the best of examination and the investigation, in my opinion, death occurred at the time, date and place, and due to the course of the 29a. Certifier Medical investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and ma 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elenewa

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year W: MMer :25 AM 10 ८००९ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fairhaven Health Care Center Sykesville Carroll County 8. Date of Birth (Month, Day, Mar 30, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1 □ M 2 👿 F 213-38-8453 1909 100 VA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Evancing In all the notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Vernon Crumpacker Maggie Flora ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 288 Westminster, MD 21158 Mr. Lewis W. Wimmer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation :10/13/2009 Sykesville, MD 21. Signature of Funeral Service Licenses HATCHT FUNERAL HOME & CHAPEL, P.A. MO0764 Hu PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) vantraler **Physician** Sysplic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to infinitelying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐Yes 2 ☐ No 1 □ Yes 2 1 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the I within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (tem 23a) (Type, Prin

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Mary d 2 should auth and Mary is maller traumat		19a. Informant's Name/Relationship (Type, Print) Pamela L. Hopkins Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City 1424 Regent Street Annapolis, M										Code)						
Baltimore, sernit. Page 1 and Department of Hea Important: If item mortant: If item any injury or other		20a. Method of Disp 1 ဳ Burial 2 4 🗌 Donation	☐ Cremation	3 □ Ri pecify)	emoval fro	m State	l c	Place of Dispersion of Dispers	osition (\)	lame of r other plac	ce)		Date	20c.	Location - napol	City or To		
Balt permit. Departi Import any inj once.		22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between													01			
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but madical Certificate.	iysician/ Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ₽ 9 ☐ Unknown	months?	23		e Birth egnant a	of pregna 2 Feta t time of c	al death 3	☐ Ectopi		Sy.				23d. Date Mor	e of delive	. ,	'ear
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Amend 29c, per DVR 9896 10/29/09 TT
State of Maryland? Department of Health and Mental Hygiene Reg. No 2009 34790 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** $\boldsymbol{A}^{\mathsf{M}}$ 10/8/2009 9:25 ADELE B. YOUNG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Marlboro Prince George's 12703 Water Fowl Way Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗓 F Yrs. Director 10/13/1918 Washington, DC 90 578-32-5988 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 23a Funeral 545 25th Place 20002 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 jo. 1 ☐ Yes 2 ☐ No Specify. Specify: Black þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 Is marked other th any Injury or other traumatic event, the once. 12 <u>Homemaker</u> <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucius Belcher Annie Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Bell / Daughter <u> 12703 Water Fowl Way Upper Marlboro, MD 20774</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10/10/2009 Riverdale, Maryland Riverdale Park 21. Signature of Fineral Service Licen 22. Name and Address of Facilitope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Xarec 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DeBility
Due to (or as a consequence of): **Physician** /Medical Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specifical Daughter House မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After. 1 Natural 5 ☐ Pending investigation Injury To the Hospina. -. within 24 hours after death.

To the Funeral Director: Aft 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number **R088852** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CRN

JK 4

State Registrar TITINGEEN C. D'AMON J 25 MAIN STREET \$200, REISTERSTEWN, MAIYLAND 21136.

31. Date filed (Month, Day, Year)

OCT 15 2009 Lenux D. Savel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery 1 - State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Richard Anderson October 0 2009 4:00 P. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3905 - 5th Street N/ABaltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ohio 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days Months Hours 1 ♣M 2 ☐ F 59 300 48 2769 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TXYes 2 □ No N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3905 - 5th Street 21225 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🏝 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2K No If Yes, Give 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Small Business Owner vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Estelle Anderson Della Rae Cochran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 - 5th Street Ginger Anderson / wife Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/31/2009 Baltimore, Maryland 4□Donation 5XIOther (Specify) EntombmentCedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1, Enter the disease, or complications that caused he death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Physician */Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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"natural"

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permit. Pages 1
Department of I
Important: If ite
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Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner by Physician/Medical Be Completed

signed by the a page Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):		ndrome onary D		
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
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Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory)	ory, office	28f. Location (St City or Town	treet and Number or R n, State)	lural Route Number,
edical (ysician: To the best of my kno niner: On the basis of examina and manner stated.					
ž	29b. Signature and title of certifier		1	29c. License number	2	9d. Date signed (Mont	th. Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Gracia **Physician** 9:35 AM 2009 taurlar /Medical Facility Name 4c. County of Death (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A altimare (14 uiversit aryland B f Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 03/17/1946 7. Age (In yrs. last birthday) 63 Yrs. Social Security Number **Funeral** 1 □ M 2 🖁 F Days Hours Panama None Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show 1 ☐ Yes 2 X No Juan Diaz Funeral Director Panama 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #32 URB. El Milagro Panama 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 ò 1 X Yes 2 □ No Specify: Panama Specify: the Mudical Eyer Completed by 3 ☐ Widowed 4 ☐ Divorced Latin "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Panama Health Dept. 12th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked ott Brigido Aguilar Cenovia De Gracia or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, Maryland 21061 Roberto De Leon 408 Morningside Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore, Maryland 10/28/2009 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 art 1. Enter the disease, are of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Fart 1. Enter the disease. Onset and Death Immediate Cause (Final disease or condition resulting in death) Small bowel **Physician** Ischenia hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Ventricul certificate anemysm 2 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Inpatient 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe Baltimore MD 2120 State Registrar DHMH 17 Rev 1/2001

			For Amend Item 26 per Registrar	(sertificate of t	Jeatn 			
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	Funeral Director		5. Social Security Number 6. Sex 7. 1 № M 2 □ F 7.	Age (In yrs. last birth	i Months i Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 9,	Year) 9. Bird 1941 Sout	thplace (State or Foreign cuntry) Th Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town of	or Location				10d. Inside City Limits
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	or 28a	Director	10e. Street and Number		10f. Zip Code		11	Og. Citizen of What Co	ountry?
	s 23a	ral	1909 Ruxton Avenue	- Francis II C	21216	lionania Origin? (Sr	ecify Ves or No-	USA 14. Race - Ame	erican Indian
030	be filed within 72 hours after death with the Maryland and Hygiene. dictiber than "natural", or items 23a or 28a-f show either than "natural", or items 23a or 28a-f show event, I've Medical Evandrier in ust by notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	No	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No		Rican, etc.)	Black, White Specify: b1	e, etc.
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DHMH 17 Rev 1/2001

36

Fry to ME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Mae Bullock October 0 18. 2009 6:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton View Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs 245-56-0930 75 **Director** March 13, 1934 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Extering any sust by natified at Director 1 ☐ Yes 2 No Prince George's Clinton MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9211 Stuart Lane U.S.A. 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 h (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Howard University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked c any injury or other traumatic Lemon Epps 2 Lucy Bullock 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8022\,$ Grayden Lane Brandywine, MD $20613\,$ Antonio Savoy 20b. Place of Disposition (Name of cemetery, crematory or other place)
Burchette Chapel
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 10-24-09 Manson, NC 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility Boyd's Funeral Service PO Box 31, Warrenton, NC Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ATherosclerot /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Juli to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Year 5 Other (specify) P.0. the a∏Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XINo certificate 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number ing 1 fan 1/ \$10/ ff warbyten Ma 2074 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Or Takelle Mar

29a. Certifier

ISABELLE TIACRETOR, 700W 40 % STREET, BALTIMORE, MD 21211 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parke

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

013657

29d. Date signed (Month, Day, Year)

October 22, 2009

			1 - For State Registrar	State of Ma	aryiano .		artment of F rtificate of a		Mental Hy	giene Reg. No	2009	34796
	Physici	an	1. Decedent's Name (First, Middle, Last						2. Date of De Month			3. Time of Death
	/Medi			Pugh C	. Bui	nch,			OCHOBE		7,2009	10:40 PM
	Examir	ner	4a. Facility Name (If not institution, give	,	. 1		4b. City, Town, o Balti	r Location of Dea	th		. County of Deat	h
	Funeral		Union Memorial 5. Social Security Number 6. Sec	7. Ag	e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs		rth	9. Birt	hplace (State or Foreign
	Director		244-20-2836 Usual Residence of Decedent	M 2□F	84	Yrs.	Months Days	Hours Min	. (Month, Da 7-20			N.C.
	death with the Maryland ms 23a or 28a-f show	-	10a. State 10b. County		10c. City, To							10d. Inside City Limits 1 Yes 2 □ No
	he Ma	ectc	MD N/A 10e, Street and Number		Bal	timo				10 07	tizen of What Co	
	23a or	Ē		C t t-			10f. Zip Code	21218		. "		untry?
	death ms 23	nera	2700 N. Charles	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of H fYes, specify Cuba		Specify Yes or No		14. Race - Ame	
21215-0036	urs after al", or ite	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🗷 Divorced	Armed Forces? 1 ☐Yes 2 ☐ If Yes, Give Year or Dates:	No		fYes, specify Cuba	an, Mexican, Puel	rto Rican, etc.)		SpecifyBla	,
5-0	72 hc 'natu	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	1	6a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	oation during most of we	orking	16b. K	and of Business/	Industry
121	within ene. than	gu	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Wel		al)		В	ethleh	em Steel
d 2	filed \ Hygid	ပို	11th grade 17. Father's Name (First, Middle, Last)	IN/ A		Mei	der	18. Mother's Na	me (First, Middle	, Maiden	Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Mudical once.	To Be	Pugh C. Bunc	h, Sr				Georg	giana		ŕ	
ary	and N	_	19a. Informant's Name/Relationship (Ty		1	19b. Mailin	g Address (Street	and Number or R				•
Σ,	and 2 lealth m 27		Sharon Bunch-D	aughter			Woodbo				to, MD	
Baltimore,	ges 1 If of H If itel		20a. Method of Disposition 1	emoval from State	20b. Place ceme	e of Dispo: etery, cren	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State
i iii	it. Pa rtmer rtant: njury		4 Donation 5 □ Other (Specify)		⊥Gar	riso	n Fores	t 11-	3-2009	Qwi	ngs Mi	lls, MS
Ba	Depa Impo any is		21. Signature of Funeral Service License	ou	ر_ه	22	1101 E •					MD 21202
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each lir	the death. [Do not ente	er the mode of dyir	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between
-4	Physician		Immediate Cause (Final disease or condition	ASPIR	ZATIO	77	PNEW	AINON				Onset and Death
ų	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):						
		e.	Sequentially list conditions,	The to for as	nonsequent	ne offr						
	uted d ansit	Examiner	Sequentially list conditions, if any early conditions, if any early cause. Enter Underlying Cause (Disease or injury that initiated events	DEM	TIA							
ó	e exec an an irial-tr	Exa	resulting in death) Last	Due to (or as	a consequen	ce of):		·				
68760,	tificate be executed ig physician and as the burial-transit	ledical		l				·- ··				
	ertific ding p		IF FEMALE:	T. 1								
.O. Box	Physician: The law requires that the death cert this certificate has been signed by the attendin rai director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3□	Ectopic pregnanc Other (specify)	у			23d. Date of del Month	ivery Day Year
σ,	s that med b		Part II. Other significant conditions con	-		g in the ur	derlying cause give	en in Part I.	23e. Did t	tobacco i	use contribute to	the cause of death?
ğ	w require been sig should b	ed b	PULMONARY	ASBESTO!	212				1 🗆	Yes 2	□ No 3□ Pr	obably 4 Unknown
Records,	The law reate has be	Completed by							24a. Was auto perfo 1 □Yes		prior to death?	topsy findings available completion of cause of
Vital	ysician: The is certificate hidirector, page	Be C	25. Was case referred to medical examiner?						ath (Check only o		7 12103	E 140
of \	Physic this c		1 ☐ Yes 2 ☑ No		nt 2 ER/			4 Li Nursing i	Home 5 ☐ Resi			cify)
'n	ding F	Certification: To	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry 281 v, Year)	b. Time of Injury	28c. Injur Work	yat k? Yes 2 □ No	28d. Describe	how injui	ry occurred	
Division	Attender death	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At home.	, farm, stre		res ZLINO	28f. Location (Street ar	nd Number or Ru	ıral Route Number,
Ę	al or safter	Serti	4 ☐ Homicide determined	building, etc	c. (Specify)		, ,,		City or To	wn, State	9)	,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tir restigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s date and	s) and manner as d place, and due	s stated. to the cause(s)
	Vithi Vori	Ž	29b. Signature and title of certifier	11 -	A		29c. License	e number		29d. Da	te signed (Monti	h, Day, Year)
	- 11		Mug x	e Me	MD)	AT2	438 941	خ	OCT	OBE12 2	27,2009
	211		30. Name and address of person who co	mpleted cause of d			,	HOSPITH	BALTI	Mor	ZE, MD	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature			10111111	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,	-011.12	
	Registr	ar	лст 3 о 20	19 Jenes	a A	b	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 2009 34797 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Kunch 7:27 PM ellie October 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Bayview Care Center Baltimore Hepkins 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-1-1929 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 1 ☐ M 2 ☐ XF 80 239-38-0893 Director N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1**▼**Yes 2□No Director MD N/A Baltimore with the 10e. Street and Number 10f, Zip Code 10q. Citizen of What Country? 2524 Garrett Avenue 21218 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other themany injury or other trainment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 □Yes XINO Specify Black 3 Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) 12th grade LPN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Battle ပ Eva Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Bunch-Daughter 2105 Woodbourne Avenue Balto, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 10-31-09 Timonium, MD 21. Signature of Funeral Service Licenses 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrhythmia **Physician** disease or condition resulting in death) minutes /Medical Due to (or as a consequence of) Examiner days uremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transi tailhre days renal Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. signed by the a d be detached for ∐Yes 2√ZNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Obstructive Kulmonar cate has been si page 2 should b 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed Bronchiectasis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Hospital: Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. injury at Work? 28d. Describe how injury occurred Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1004383 October 26, 2009

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hop kins W, 3, Greeneyth F HD Baltimore, no Baltimore,

Bayview Circle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** 11:00 2009 27 /Medical 4a Facility Name (If not institution, give street end number 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Murboro Prince Georges Conce Largo
6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Manor Birthplace (State or Foreign Country) 5. Social Security Number Funeral Months Days Hours Min 1 □ M 2 🔀 F 88 Yrs. 206-20-9727 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 28a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be appeared. 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Prince Georges Upper Marlboro 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 11407 Abbotts Wood Court Funerai 14. Race - American Indian, Black, White, etc. African American 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Minor Samuel Lawson 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, S. Cynthia Bond Henderson/Dau 349 E. Sharp Neck, Phil, PA 19119 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/31/09 Phil., PA Mt. Peace Cem. 22. Name and Address of Facility Hari P. Close F. Svs. 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Furieral ervice Licensee Svs, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** . Al 3 hermer's disease, Advanced /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ၉ Other: 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA completaly filled in by tha funeral 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 27. Mannet of Death 28d. Describe how injury occurred Medicai Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-29-2009 D51520 employed cause of deeth (Item 23e) (Type, Print) 20032 D C MOJAHINGTON 1328 5 outhern AVR JE # 310 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

30 2009

3altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

fares

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:10 P.M John Henry Brown, Jr. October 2009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner nes Health saltimore N/A 8. Date of Birth (Month, Day, Year, Mar. 21, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. **№** M 2□ F 63 Maryland 1946 **Director** 218-42-5412 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, If a Medical Exertine must be notified. 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 22 South Athol Avenue Funeral United States Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No Specify ò White ¾☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Public School System Custodian permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important; If item 27 Is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Henry Brown, Sr. Ola Mae Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte Keirle - POA 3 Chester Circle, Glen Burnie, MD 21060 20c. Location - City or Town, State 20b. Place of Disposition (Name of opmetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 10-28-2009 Glen Burnie, MD 5 ☐Other (Specify) tur of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _____ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NKNOWI MONARY **Physician** PMBOLISM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) $D U W R J \theta M M H L M M$ Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 □ PR/Outpatient 3 □ DOA e Hospital or Attending Phys 24 hours after death. e Funeral Director: After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Two certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BP9619430 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore Maryland Saint Agres Hospital 900 East Cator Avenue 31. Date filed (Month, Day, Year) State OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34800 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2009 <u>Clara Marie Blair</u> 2:44 РМ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days July 25 1 M 2X F Hours Min. **Director** 1922 Maryland 215-18-8819 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or or 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Abingdon 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 21009 10g. Citizen of What Country? USA Funeral 3220 Peverly Run 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married by If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th 10 Sales Audit Clerk Department Store Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Charles Cumberland Catherine Marie Nau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21009 Robin Gaines / Daughter 3220 Peverly Run, Abingdon, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Sp Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oaklawn Cemetery 10/30/09 Baltimore, Maryland 21. Signal Aof Fundral Serve icensee 22. Name and Address of Facility McComas Funeral Home Rd., Abingdon, MD 21009 Menly 317 COKESbury 23a. Part 1. Enter the disease, or oshock, or heart failure. List only of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. END Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No
9 Unknown Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 1 Natural 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Xcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HAROLD BERMAN 2 (21/219 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death
Baltimore Joseph Medical Center Towson Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) I N Months Days Hours Min 310-20-9050 160°69°479°25 **Director** 84 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked meter than "natural", or items 23a or 28a-f sho it is marked event, the Medical Examiner must be notified at reumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🗶 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9401 WORDSWORTH WAY, #404 USA 21117 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) ACCOUNTANT ACCOUNTING 27 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY BERMAN RACHEL BRILL .f. Page 1 and 2 shou.

"et of Health and Me"

"et 27 is me
"saur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEWIS BERMAN/SON 404 SELBY COURT, BALTIMORE, permit. Page 1 and 2 Department of Health Important: If Item 27 any injury or other to MD 21212 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 10-28-2009 REISTERSTOWN. Sign rure of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ CONJESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examine ARRYTHMIA HOUR Gequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1
Yes 2
No ξ Month Year Pregnant at time of death 5 Other (specify) Day 4 ☐ Pregnant : g ☐ Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be d 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 autopsy performed? After this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) maso D39215 address of person who completed cause of death (Item 23a) (Type, Print) CUNNINGHAM OSLER TOWSON. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 0 2009 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 27, 2009 **Physician** 2:10 P M Richard Edgar Budd /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 1401 Bernerd Place Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 24, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2 □ F 1927 Pennsylvania 82 203-20-0298 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shov 1XYes 2□No Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 USA 1401 Bernerd Place by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or ite Lry or other traumatic event, Ite Medical Examina. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1944-74 1 □ Yes 2 Ϊ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pathology Research Technician Federal Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph M. Budd Margaret E. Jolley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris S. Budd/wife 1401 Bernerd Place Rockville, MD 20851 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Final Journey Crematory 10/29/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ging Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Liver Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Colorectal Carcinoma 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐Yes 2 XNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1∐ Yes 2 🕍 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? spital or Attending Piours after death.
neral Director: After t After t 28d. Describe how injury occurred 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 1 🗗 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25 MAOR421000 سر الا الا 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Marijo Bilusic, M.D.

31. Date filed (Month, Day, Year)

ORIGINAL

8901 Wisconsin Ave. Bethesda, MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH G896 10/30/09 TT

State of Maryland / Department of Health and Mental Hygiene 2000

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28 9:45 A M -041S 10 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore** Catonsville Charlestown Care Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min Yrs Director 84 433-34-3472 Nov 29, 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 1 ☐ Yes 2 No Director **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR626 21228 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NSA Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Blom Elsa Fenety မ or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace Blom spouse 719 Maiden Choice Lane BR626 Catonsville, MD 21228 20a. MetMod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) St. Louis Cemetery Nov 04, 2009 Clarksville, Maryland Licensee 21. Signature of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) potal or Attending Physician: The law requires that the death certificate be executed ours after death.

Lead Director: After this certificate has been signed by the attending physician and filled in by the funered director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 Yes 2 No 3 Probably 4 thknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 HNo 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a, Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 711 Bowlin Deneen MD Ma

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

32. Registrar's Signature

31,801,

Physiciai	
/Medica	
Examine	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hyriene.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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ian cal	1. Decedent's Name (First, Mide GERAL		E. BA	ARNES				2. Date of Dea Month October	Day 26,	2009	3. Time of Dea 3:00 p
er	4a. Facility Name (If not instituti 7797 FOX	ion, give street and nu	umber)		PAS	wn, or Location ADENA			4c. Coun	ty of Death E Aru i	ndel
	5. Social Security Number 213–38–9452 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. 69	. last birthday) Yrs.	If Under 1 Months E	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day Oct. 5,	1940	9. Birthp Coun Mary	lace (State or Fo try) Land
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ctor	Maryland An	ne Arundel		Pasao	lena						1 ☐ Yes 2
Funeral Director	10e. Street and Number 7797 Fox Cou	ırt			10f. Zip Co	ode 21122			10g. Citizen o	f What Coun S.A.	try?
þ	11. Marital Status 1 Marital Alever Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Fearried 1 ☐ Yes	cedent Ever in U orces? 2 MNo ive oates:		Was Deceder If Yes, specify 1 □Yes 2	t of Hispanic O Cuban, Mexica No Specify		ecify Yes or No- Rican, etc.)	14. R Bl	ace - Americ ack, White, e hify: Whit	etc.
ete	15. Decede (Specify only high	ent's Education nest grade completed))	16a. Dece	dent's Usual (Occupation done during mos retired)	st of workir	ng	16b. Kind of	Business/Ind	lustry
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Be C	17. Father's Name (First, Middle	e, Last)		1			er's Name	(First, Middle,			,
P B	George Harold	Barnes				Th	elma	Marie	Carson		=
100	19a. Informant's Name/Relation Marie Chris Cros		;)			itreet and Numb					
	20a. Method of Disposition		20b. F	Place of Dispo cemetery, cre	sition (Name natory or othe	of er place)	D	ate	20c. Location	- City or To	wn, State
	1		State	v Cather		i	10-30-	09	Baltimo	re, Mar	yland
	21. Signature of Funeral Service	(icensee)	1/2	2. Name and	Address of Facil ntain Rca	ity McCu	11y-Po1yı	niak Fun	eral Ho	me P.A.
	Sequentially list conditions	H	(or as a cycled		TC (byonc	ary	Arter	21 C P	Lase	Onset and Dea
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sician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to c. Due to d. 23c. If yes, or	(or as a consequence of pregnia birth 2 ☐ Feta grant at time of	quence of): quence of): quence of): quence of):	M □ Ectopic prec □ Other (spec	gnancy	ary	Heter	23d. E	Date of delive	ory
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To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are in the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medic examiner? 1 Yes 3 No 27. Manner of Death	b. Due to c. Due to d. 23c. If yes, or or or or or or or or or or or or or	(or as a consequence of pregnal at time of a grant	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u S BER/Outpatie 28b. Time of Injury owne, farm, strify) owledge, deat ation and/or in	Detectopic pregoner of the control o	gnancy ify) 26. Plac Other: 4 □ N Injury at Work? 1 □ Yes 2 □ ffice the time, date a my opinion, de icense number	I. e of Death tursing Hor 2 3No 2 and place, ath occurre	23e. Did to 1	23d. E	Date of deliver Month all Prob D. Were autoprior to condeath? 1 Yes Other (Specification of Paura) The manner as see, and due to the model (Month, interpret)	Pry Year Day Year Day Year Day A Unkr Day findings avain Poly findi

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 1:30 M David Clarke Oct 26, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Angels Touch Assisted Living

5. Social Security Number | 6. Sex / | 7 ^ _____ Howard West Friendship If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Director MD 212-16-5649 Sep 20, 1918 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director **Ellicott City** MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21042 U.S.A. 4556 Kingscup Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Çuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1/9/1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò While 3 Widowed 4 Divorced "natural", 8/25/1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life, DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MD. State Chemist State Govt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janie Clark ို John Ridgley Clarke permit. Pages 1 and 2 should Department of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4556 Kingscup Ct. Ellicott City, MD 21042 Theola Clarke Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Oct 28, 2009 Glen Burnie, MD Atylantic Crematory, LLC 21. Signature of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. En The dise ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each li Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Due to (or as a consequence of): physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear ☐ Pregnant at time of death
☐ Unknown 5 Other (specify) signed by the a o 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform certificate 2 No 2 🗆 No 1 Tyes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ZNO Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier **Medical** and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 10 son who completed cause of death (Item 23a) (Type, Print) Name and address of 05 Digital DR nol Steg. Linthicum, MD State

Registrar

09-08070	
Roger C. Clay	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	,,	Reg.	No. 200	9 3480
Physicia Medical Exami	in/	Decedent's Name (First, Middle,Last)		Date of Death Month D	ay Year	3. Time of Death 1628 hrs
vieulcai Examii	ilei	Roger C. Clay	or Location of Death	October 17,	4c. County of Death	
		2208 Elsinore Avenue Baltimore			,	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes Months Day		8. Date of Birth(MM/DD/YYYY) 9. Birt Foreig	n
Director		213-56-7/90 1XM 2 F 55 Yrs.	ys Flours Will.	June 19	, 1954 Coi	^{Jntry)} Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Varyland 28a-f show any 1 at once.	ō	MD Baltimore				1 X Yes 2 No
Maryl r 28a-	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cour	ntry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	al D	2208 Elsinore Avenue 212 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi		cify Ves or No-	USA T14 Race Ameri	can Indian, Black,
death v	Funeral		an, Mexican, Puerto Ri		White, etc.	oarr maan, bloos,
after a	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No	o specify:		Specify: blac	rk
2 hours	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupa during most of working life	ation (Give kind of wo ie. DO NOT use retired	rk done unk 10	6b. Kind of Business/I	ndustry unk
036 ithin 7 ne. r than	Completed	12 0				
21215-0036 ould be filed within 7 Mental Hygiene. marked other than it event, the M dir			18.Mother's Name (F	First, Middle, Mai	den Surname)	
212. uld be Menta marke	To Be	Raymond Clay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streen)	Lula Be	ll Harri ral Route Numbe	.S er, City or Town, State	, Zip Code)
MD d 2 sho lith and n 27 is aumati		Julie Clay/daughter 851 Benningh.				
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of ce crematory or other place)	emetery,	Date 2	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of He. Important: If ite		4 Donation 5 X Other Specify: in state				
Bal permi Depar Impo	Į	21. So ture of Euroral Service Licensee Ronald S. Wade Director State Anat Baltimore,	tomy Board MD 2120	655 W.	Baltimore	Street
Physician	7	23a Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line. Acute carbon monoxide in	, such as cardiac or r	espiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical vaminer	i	Immedian cause (Final disease a heroin intoxication and coca		n compi	cating	Death
	- 1	or condition resulting in death) Due to (or as a consequence of): b.				
	ie l	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
recuted		d.				
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 23a,27,28a-f,perME, g8 IF FEMALE: 23c. If yes, outcome of pregnancy	398 12/10/	09 TT	23d. Date of delivery	
Box 68760, deatt certificate be he att nding physic d for se as the but		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnance	су		/ Day Year
Soy death o	Physician	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown				
P.O. B es that the degree by the detached is		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S, P.(ed by					pably 4 Unknown
of Vital Records, g. Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
tal Rec clan: The l certificate ector, page	틼			1 ✓ Yes 2		es 2 No
n of Vital Recting Physician: The After this certificate funeral director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing		esidence 6 🗸 Other	: Scene
of Ving Phy	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Inju	ury at Work? 2	8d. Describe how	w injury occurred in	haled fumes
Division tal or Attendir s after death. al Director: A	Certification:	Pending Fd 10/17/09 Fd 4:28 pm	Yes 2 2 No h	ouse		
Division pital or Attenc ours after death teral Director:	Ĭ	3 Suicide 6 Could not be determined (Specify) house	0.00			ral Route Number, City ninore Ave
Hospit 24 hour Funer tely fill		4 Homicide (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, d		altimore		ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the deatt certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the att. Inding physician and completely filled in by the funeral director, page 2 should be detached for sees the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.				
	Σ	29b. Signature and title of certifier 29c. Licens			29d. Date signed (Mo.	
		Montone of nechal	.M.E.		October 18, 2009	7
_	-	 Name an address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, B 	Baltimore, MD 2	1201		
Sta	ite	31. Date filed (Month, Day, Year) 34. Registrar's Signature	 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Kathleen Drezner October 30, 7:12 A M 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 66 Franklin Street, #207 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1 □ M 2 🔀 F 144-32-7970 68 07/18/1941 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 66 Franklin Street, #207 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis M. Cryan, Sr. Catherine Fitzgerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Malcolm Drezner, Husband 66 Franklin Street, #207, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 11/06/2009 | Ewing, New Jersey Ewing Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur Fucera Service Licensee T. Harman Wm. Murphy Funeral Home 935 Parkway Avenue, Ewing, New Jersey 08618 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 vain cancer ololastoma MOS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

ral", or items 23a or 28a-f sho

"natural",

th and Mental Hygiene.
?? is marked other than "natur traumatic event, the Medical

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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physician a s the burial-1 attending p has been signed by the e 2 should be detached r this certificate had are rail director, page 2 After I Director: ,d in by the f

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical þ Completed Be Certification: To

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

1 ☐Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Bestgate Rd. Annapolis, Und. 2140)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of dertifier

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selonick, MO

31. Date filed (Month, Day, Year)

MICH ON ZUUS

32. Registrar's Signature

State Registrar

within 24 hours at To the Funeral D completely filled in To the Hospital

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Amend #7 & 8 per Fh g897 11/5/09 TT Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 10 28 DENNIS DROST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Sa Roseda uare more 8. Date of Birth 2/10/1948. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year ge (In yrs. last birthday) **Funeral** Min 1**X** M 2□ F 214-56-6299 60 68 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show 1 ☐ Yes 2 X No MD BALTIMORE ROSEDALE Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9013 TARPLEYS CIRCLE 21237 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2X No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FUNERAL HOME 12 DRIVER 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEO JOHN DROST MILDRED KELLNER ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 any injury or other trong once. LEO DROST- BROTHER 9328 SEVEN COURTS DRIVE BALTIMORE, MD 21236 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/09 ATLANTIC CREMATORY BALTIMORE, MARYLAND 22. Name and Address of FacilityMILLER-DIPPEL FUNERAL HOME 21. Signature of Funeral Service Licensee 6415 BELAIR ROAD BALTIMORE, MD 21206 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0515 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this After th funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🖪 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral Cletely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical Check only 24 one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier OOTUBER 28,2005 D0060520 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7-208, BAGIMORE, MD. 21237 9106, PHILADELPHIA RD KHETETZPAL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Marylan	d / Depa <i>Ce</i>	artment of He rtificate of D	ealth and <i>eath</i>	d Mental Hy	giene (2009	34809
			Decedent's Name (First, Middle, Last	st)				2. Date of De	ath		3. Time of Death
	Physicia		РАП	DENNIS DUNM	/IID			Month October	Day 24.	2009	8:55 a M
1	/Medic Examin		4a. Facility Name (If not institution, give		LLil	4b. City, Town, or l	Location of De			ounty of Death	0.55 4
	LAGIIIII	CI.	1508 Marco Drive			Pasader	na		1	Anne Arun	del
	Funeral		Social Security Number 6. S		last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Bir	th av. Year)	9. Birthp	lace (State or Foreign
	Director		216-40-0429	M 2□ F 66	Yrs.	Worldis Days	riours ivi	Nov. 1	5,194	2 Mar	yland
	pu:		Usual Residence of Decedent 10a. State 10b. County	10c City	y, Town or Lo	ecation				1	0d. Inside City Limits
	shor	٦				, canon					1 □Yes 2 No
	the M	Director	Maryland Anne A	rundel Pas	adena	10f. Zip Code			10g. Citize	en of What Coun	itry?
	with Ba or	Ö					21122		J	U.S.A.	•
	ns 23	Funeral	1508 Marco Drive	12. Was Decedent Ever in U.	S. 13.	Was Decedent of His If Yes, specify Cuban		(Specify Yes or No	D- 14	4. Race - Americ	
ယ္	r iter		1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🐧 No		If Yes, specify Cuban 1 ☐ Yes 2 No		erto Rican, etc.)		Black, White,	etc.
03	ours a	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		TLIYES ZALINO	Specify:			Specify: Whi	te
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa kind of work done du	uring most of v	vorking	16b. Kind	d of Business/Inc	dustry
121	filed within Hygiene. ther than "	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			Sı	inoco Oi	1 Co
2	iled v Hygie ther t		12 17. Father's Name (First, Middle, Last)	N/A	11	ruck Drive		lame (First, Middle			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Be c		mond	Dunmye		Lorra		Rut		rd
<u> </u>	should nd Mo mark	10	19a. Informant's Name/Relationship (ng Address (Street a					Code)
\leq	and 2 s ealth a n 27 is ner trau		Robert Dunmyer (S		1508	B Marco Dr	ive Pa	sadena. M	iarvla	and 2112	2
<u>o</u>	s 1 and 2 if Health item 27 i		20a. Method of Disposition			osition (Name of matory or other place		Date		ation - City or To	
E O	Page: lent o nt: If		1 Burial 2 Cremation 3 □ 4 Donation 5 Other (Specification 5 Other (Spe	Removal from State	-	ven Mem. P		/28/09	G1er	n Burnie	, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licer		2:	2. Name and Address	s of Facility				, , , , , , , , , , , , , , , , , , , ,
m	B a l be		John J	Efficient .		1cCully-Po 3204 Mount	ain Ro	ad Pasade	ena, M	Maryland	21122
П			23a. Part 1. Enter the disease, or company shock, or heart failure. List only	plications that caused the deatl one cause on each line.					arrest,		Approximate Interval Between Onset and Death
24	Physician		Immediate Cause (Final disease or condition	· Met	e styl	ric Ades	10 Car	cind A	e Yr	1	10 es outh
. set	/Medical		resulting in death)	Due to (or as a conseq	uence of):				-		
	Examiner	<u>_</u>	Sequentially list conditions,	b							
,	led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence or):						
(and and	xan	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
58760,	ficate be executed physician and s the burial-transit										
687	rtificate ng phy as the	edical		u							
Вох	leath certifi attending I for use as	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7			2:	3d. Date of deliv	rery
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		☐ Ectopic pregnancy ☐ Other (specify)				Month	Day Year
P.0	res that the de signed by the a be detached to	hys	9 Unknown	9 Unknown							
	gned be de	by F	Part II. Other significant conditions	ontributing to death but not res	ulting in the u	inderlying cause give	n in Part I.	\ \ \ \	,		he cause of death?
ord	w requir been si should I							_ 1,25	Yes 2	No 3 Pro	babiy 4 ☐ Unknown
Records,	e law r has be	Completed						24a. Was	psy	prior to co	opsy findings available empletion of cause of
=	The sate h	Son							ormed? 2 KNo	death? 1 □ Yes	2 X io
Vital	Physician: this certific ral director, I	Be	25. Was case referred to medical examiner?	Licenite I.		Otho		Death (Check only	one) 5	Soo's H	one
of	Phys this al dir	ျ	1 Yes 2 Nanner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie		4 LI Nursin	g Home 5 Res 28d. Describe		Other (Speci	fy)
	Jing After fune	ion	Natural 5 ☐ Pending	(Month, Day, Year)	Injury	Work	rat ? /es 2□No	260. Describe	now injury	occurred	
Division	I or Attendi after death. Director: A I in by the fu	fical	3 Suicide 6 Could not b		ome, farm, st		2 2 110	28f. Location	(Street and	f Number or Run	al Route Number,
Ξ	after Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Specil	fy)	•		City or To	iwn, State)		
	ospita hours inera ly fille			nysician: To the best of my kno							
0	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one)	niner: On the basis of examina and manner stated.	and/of I			roouned at the time			
_	Neith Vith Con Con Con Con Con Con Con Con Con Con	Σ	29b. Signature and title of certifier	71		29c. License	number	F/	29d. Date	e signed (Month,	Day, Year)
			1///	CIUS.		- 2	113.	/ /	Ve	ナークター	26, 6004
			30 Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	0 0-	· Cila	0	- MJ	21011
	Sta	to	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature _	1705017e	4 01	1 1 1 Co	المالار	1811-1	-000/
	Sta Registr		31. Date filed (Month, Day, Year) QCT 3 0 200	19 Cerous &	1. 40	Made					

		4	State of Mary State Registrar	land / Depa/ <i>Cen</i>	artment of H tificate of D	ealth and M eath	lental Hyg	iene 20(9 34810
	Dhysisia		Decedent's Name (First, Middle, Last)				Date of Deat Month	n	3. Time of Death
	Physicia Medic	al	Carl Hanna Durha 4a. Facility Name (if not institution, give street and number)	am	Al- City Town		Octobe:		09 12:57 am
	Examin	er	Gilchrist Hospice		4b. City, Town, or TOWSO			Baltin	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 19	Year) 1934	9. Birthplace (State or Foreign Country) NC
	and show Lat	o		c. City, Town or Loc		144			10d. Inside City Limits
	Maryla 28a-f	Director	MD		Ba.	ltimore ———		0g. Citizen of Wh	1 Yes 2 No
	with the	Funeral [10e. Street and Number 4408 Roland Avenue		212	10		USA USA	
9200	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	Lf	Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2 🔀 No	n, Mexican, Puerto			American Indian, White, etc. White
15-(i 72 hou in "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of Busi	iness Industry
212	within ygiene. her tha t, the I		12 4		Legislat				Government
land	l be filed lental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last) James Cicero Durham			18. Mother's Nam Beverly	y Maude Maude	Hanna	
Mary	d 2 should alth and M 1 27 is ma or traumal		19a. Informant's Name/Relationship (Type, Print) Mary Anne Durham / Wife	19b. Mailir 4408	ng Address (Street & Roland A	venue, Ba	al Route Number, altimore	City or Town, Sta MD 212	te, Zip Code) 10
Baltimore, Maryland 21215-0036	Page 1 and ment of Hermant: If item		1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, cren Final Jour	natory or other plac	e) !	Date 9/2009	20c. Location - C	ne, MD
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee Porcota, Mar	rshall 22	Name and Address Marylan PO Box	d Crema 1413, B	tion Se altimo:	ervices re, MD	21203
No. of the last	Inysician Medical Examiner	ı,	Sequentially list conditions.	nsequence of):	er the mode of dying		or respiratory arre	st,	Approximate Interval Between Onset and Death
	ate be executed ohysician and the burial-transit	dical Examiner	If any, leading to immediate caus. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a co						<u> </u>
09	te be e; nysiciar ne buris	dical	d						
P.O. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date Mont	of delivery th Day Year
s, P.O	uires that the signed by Id be detact		Part II. Other significant conditions contributing to death but to	not resulting in the ι	underlying cause giv	ven in Part I.			oute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	The law requivate has been page 2 shou	Completed by					24a. Was a autop perfor 1 Yes	sy pr	ere autopsy findings available ior to completion of cause of aath? □ Yes 2 □ No
ital	sician: The certificate rector, pag	æ	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inputient	□ FD /O + - +-	- Oth	ace of Death (Chec		ence 6 Other	(Specify) Valle UP
n of V	ding Phys h. After this funeral d	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Natural 5 Nestigation	t 2 ER/Outpatier 28b. Time of injury	f 28c. Injur	y at		ow injury occurred	
ivisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	3 Suicide 6 Could not be	- At home, farm, str Specify)	reet, factory, office		28f. Location (S City or Town		or Rural Route Number,
	e Hospita 124 hours e Funeral	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my Certifying Nurse Practioner: To the be	mination and/or inves	stigation, in my opini	on, death occurred a	at the time, date a	nd place, and due	to the cause(s) and manner stated.
	To the I within 2 To the Complei		29b. Signature and title of certifier		29c. Licens			29d. Date signed	(Month, Day, Year) 2 28 2009
			30. Name and address of person who completed cause of deal AAUN JUHANUS W 6	th (Item 23a) (Type, I	Print) Warden S	T TOWSO	N MS)	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 3 0 2009		S)				

DHMH 17 Rev 7/2009

			1 - State Registrar	ate of Maryland / D	epartment of I Certificate of		lental Hygie Reg.	ne No.2009	34811
Z-Q:	Physicia /Medic			erg			2. Date of Death Month	Day 7-09 Year	3. Time of Death S:25PM
2	Examin	er	4a. Facility Name (If not institution, give street Le Vinda le		Bal-	Finore	-	4c. County of Death	
l	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. last birti	rs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02/28/191	9. Birthj Coul	olace (State or Foreign ontry) GEORGIA
	tryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	h the Ma r 28a-f s r notified	Funeral Director	MD N/A 10e, Street and Number	BALT	IMORE 10f. Zip Code		10g.	Citizen of What Cou	1 Y Yes 2 □ No ntry?
	sath wit s 23a o nust be	eral D	2434 W. BELVEDERE AVEN		212		neife Van au Na	USA 14. Race - Americ	oon Indian
980	ours after de ral', or item Examiner n		1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 M No es, Give ar or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 💢 No		echy Yes or No- Rican, etc.)	Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. Be other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12)	oleted) 16a. l	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire HOMEMAKER	during most of working)	ing 16t	OWN HON	,
ō	0 - 0 2	To Be C	17. Father's Name (First, Middle, Last)	CANTER			First, Middle, Mai		-
Maryland	ind 2 shou alth and M 27 is mai ir traumat	_	19a. Informant's Name/Relationship (Type. Prince GILBERT RUBIN/SON		Mailing Address (Street			ity or Town, State, Zij	
altimore,	ages 1 ant of Heart Int of Heart International Internation		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	al from State cemeters	Disposition (Name of crematory or other pla	ice)		c. Location - City or To	
Baltin	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic even		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign: ure of Funeral Service Licensee	SHAARE	I ZION CONG 22. Name and Addre 8900 REIST	ess of Facility SOL	LEVINSON	SEDALE, MI & BROS., SVILLE MI	INC.
2			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do no se on each line.	ot enter the mode of dyi	ng, such as cardiac o			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Advanced Out to (or as a consequence o	,		0		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence o	carcinon	na on	tace		
58760,	ficate be executed physician and is the burial-transit	al Examiner		Due to (or as a consequence o	f):				
_	ortificate ing phys s as the	Medical	IF FEMALE:						
O. Box	The law requires that the death certificate has been signed by the attending parage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	ves, outcome pf pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ey .		23d. Date of deliv Month	ery Day Year
О.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contribution	ng to death but not resulting in	the underlying cause gi	ven in Part I.		co use contribute to t	
Records,	w require been signature should b	leted					1 ☐ Yes	2 No 3 Prol	bably 4 Turknown ppsy findings available
al Re	(0 (1	Completed					autopsy performed 1□ Yes 2	d? prior to co	mpletion of cause of 2 No
r Vital	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospita	ıl: 1	patient 3 DOA Oti	nor:	n <i>(Check only one)</i> me 5 ☐ Residenc	e 6 □Other (Speci	fv)
o uc	ding Ph .r After th funeral	ion: T	1 Natural 5 □ Pending	a. Date of Injury (Month, Day Year) 28b. Ti	jury Wo		28d. Describe how		77
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2□ recident 6□ Could not be	Place of injury - At home, fare building, etc. (Specify)			28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	e Hospita 24 hours ie Funeral	Medical C	(Check only 2 Medical Examiner: C	To the best of my knowledge, in the basis of examination and and manner stated.	death occurred at the t l/or investigation, in my	ime, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b Signature and title of certifier	, MO, MPH	29c. Licen:			Date signed (Month,	Day, Year)
1	3/		30. Name and address of person who complet	ed cause of death (Item 23a) (1	ype, Print)	est Belie	4	10-24- Ba	timore;
_	Sta	to	31. Date filed (Month, Day, Year)	-Sayed M 32. Registrar's Signature	D 2434W	lest Belie	dete fue	rue, MI	21215

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34812 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 hn 8:17 tovo 10 200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death saltimore Baltimore HOSPICE If Under 1 Year If Under 24 Hrs.

Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 🗆 F **Director** Yrs an Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No nmone 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral ds 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes 2 No Specify 3 Divorced 4 Divorced Blac Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) rightely Elementary/Seconday (0-12) Owned College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be 0 19a. Informant's Name/Relationship (Type, Print) (1941) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Date 1 Burial 2 Cremation 3 Removal from State PASdoure 4 Dona n 5 Other (Specify) MD 21. Signat uneral Service Licensee 1 Home, 22. Name and Address 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carunoma of Nasal Cant Physician/ (ell disease or condition resulting in death) aus Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death 2 🗌 No 9 Unknown detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 2 10 icate has been sig page 2 should b 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate l 1 🗌 Yes 2 🗌 No director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 🗷 မ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sther (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 68286 10124 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towsorton Blod Baltimere 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

			For State Registrar	State of M	laryland / Depa <i>Cel</i>	artment of F rtificate of I		/lental Hygie Reg	ne 2009	34818
	Physici	an	1. Decedent's Name (First, Middle, Last)			C		2. Date of Death Month	Day Year	3. Time of Death
alice and	/Medic		Dorothy			Greer		OCTOBER		
	Examir	ner	4a. Facility Name (If not institution, give)		r Location of Death	15.7 m	4c. County of Deat Balti	
	Funeral		Season's Hospic 5. Social Security Number 6. Sec		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director]M 2∏ F	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, YO) 14	33	untry) MD
	pu ,		Usual Residence of Decedent		10c. City, Town or Lo	antion				10d. Inside City Limits
	aryla shov	ō	10a. State 10b. County							Y☐Yes 2☐No
	the M	Director	MD NA 10e. Street and Number		Balt	10f. Zip Code		10g	. Citizen of What Co	untry?
	3a or	Ö				27.	208		U.S.A	
	death ms 2	Funeral	4216 Lowell Dri	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	rican Indian,
9	72 hours after death with the Maryland inatural", or items 23a or 28a-f show dige! Exprimer must be notified at		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 24☐	l No	1 ⊡Yes 2 👿 No	Specify:	rtican, etc.)	Black, White	lack
215-0036	ural",	d b	3√ Widowed 4 □ Divorced	Year or Dates	:			10	b. Kind of Business/	
7-	n 72 h	olete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	durina most of work		D. KING OF DUSINESS/	midusti y
212	withi	Completed by	Elementary/Secondary (0-12) 8th grade	College (1-4or na	5+)	Domest:			Priv	ate
b	e filed al Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Surname)	
/ar	should be filed within 72 hours after dea and Mental Hygiene. s marked other than "natural", or items umatic event, the Medical Exemination	2	Charlie Daniels	3			Mary N	lason		
			19a. Informant's Name/Relationship (7)		_				city or Town, State, 2	
≥ o`	l and Health Health Her tu		Katherine Danie	els-Nie					c. Location - City or	
ŏ	ages 1 nt of h : If ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo cemetery, crei		i .		•	
Baltimore,	iit. Partmelartant		4 □ Donation 5 □ Other (Specify) 21. Signature of Feneral Service Licens		King Me	MOTIAL J		0/31/09	Woodlawn	r, Ma
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.	1	VY/// A / / .	C. Chris	Oal Mi	arch F/1	H West	Baltim	ore, Md	21215
			23a. Part 1. Enter the disease, or compl	ications that cause	ed the death. Do not en					Approximate Interval Between
- E	Physician		shoo, or heart failure. List only o	ne cause on each	tone led	acouste /	cardia	nunnat	thu 1	Onset and Death
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequence of):	L				
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8760,	icate be executed physician and the burial-transit	dical E		H						
		edic								
Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Fetal death 3	⊒ Ectopic pregnan	ev.		23d. Date of de	
<u>.</u>	e deal he att ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5	Other (specify)			Month	Day Year
P.0	nat the d by t etach	Phy	9 ☐ Unknown Part II. Other significant conditions co			anderlying course air	on in Port I	23e Did toba	cco use contribute to	o the cause of death?
က်	ires th signe I be d	þ	Part II. Other significant conditions co	nunbuting to death	but not resulting in the c	indenying cause gi	cirili raiti.			robably 4 ☐ Unknown
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<u></u>	ician: The certificate ector, pag		25. Was case referred to medical				OC Disease Des	performe	XNo 1 □Yes	s 2□No
Vital	rsicia s cert lirectc	o Be	evaminer?	Hospital:	tient 2 ☐ ER/Outpatie	nt 3 DOA Oti		th <i>(Check only one)</i>	ce 6 MOther /Spe	SONS HOSPIL
o o	Attending Physician: The in death. ector: After this certificate hiby the funeral director, page	Certification: To	27. Manner of Death	28a. Date of Ir				28d. Describe how		,,,,,
<u>0</u>	ath. ath. rr: After	atio	1 Matural 5 Pending 2 Accident investigation	(WORTH, 1	Jay, rear) Injury		Yes 2 □No			
	r Atte her de irecto	ţţ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	iital o urs aff ral Di								/ N	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical			st of my knowledge, dea of examination and/or installed					
	ithin 2	Med	29b. Signature and title of certifier	and manner	sialeu.	29c. Licen	se number	290	d. Date signed (Mon	th, Day, Year)
	F ≥ F 8		> Allinel	1/8115	ton					
	0 /		30. Name and address of person which	ompleted cause of	f death (Item 23a) (Type	Print)	- 101			2001
	141	1	Debrah 7	- Bur	on 5401	OLDCOL	ICT LOAD	Randa	Ilstown	MD 2009
	St	ate	31. Date filed (Month, Day, Year)		strar's Signature					
	Regist	rar	OCT 3 0 200	J /b-	4 A 100	A Real				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:00A **Physician** Graves ichard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Battimore Belle Grove) 900 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F lar Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be recitived at 1 Pres 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Belle Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Blac 3altimore, Maryland 21215-0036 1 □Yes 2 ☑No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) GGive kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wanda Carter Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Belle Grove Rd. 5900 Kartara 101 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Dispositien 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28 74/dr 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Zulle **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed oertificate has been signed by the aftending physician and rector, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **K**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m. A 31. Date filed (Month, Day, Year)

2009

29b. Signature and title of certifier

OCT 30

32 Registrar's Signatur

29d. Date signed (Month, Day, Year)

29c. License number

			For State Registrar	State of M	laryland / De C	epartmen Certificate	t of H e <i>of E</i>	ealth a Death	and M	ental Hygi	ene20	09	34815
	Physici /Medic		1. Decedent's Name (First, Middle, La	•	ne Geisler					2. Date of Death Month Octobe	Dav	Ye ar 009	3. Time of Death 8:15 A. M
4	Examir		4a. Facility Name (If not institution, give street and number) 104 Georgia Avenue				4b. City, Town, or Location of Death Glen Burnie			4c. County of Death Anne Arundel		ınde1	
	Funeral Director		5. Social Security Number 6. 5		ge (In yrs. last birtho 65 Yr	Months		If Under 2 Hours		8. Date of Birth (Month, Day, 08/08/	Year) 1944	9. Birthp Coun West	lace (State or Foreign try) Virginia
, Maryland 21215-0036	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number	Arundel	10c. City, Town o	Burnie	Codo			10	0g. Citizen of W		0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	3a or	al Dii	104 Georgia Av	enue		101. 219	21061			U.S.			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarring must be notified at once.	t by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No	13. Was Deced If Yes, spec 1 □Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		, White, e	an Indian, etc. ite
	within 72 ho liene. • than "natu the Medicel	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th 16a. Decedent's Usua (Give kind of wor. life. DO NOT us. Homemake				nd of work done during most of working O NOT use retired)				o. Kind of Business/Industry Own Home		
	uld be filed Mental Hyg Irked other Itic event, I	To Be C	17. Father's Name (First, Middle, Last) Perry Cook 18. Mother's Name (First					(First, Middle, M a Stewar	st, Middle, Maiden Surname) Stewart				
	and 2 sho ealth and I m 27 is ma	Ċ	19a. Informant's Name/Relationship (Duane Geisler /	,	66	13 Ta11	ulah	Aven	ue		ore, Mai	ry1ar	nd 21207
Baltimore,	Pages 1 ament of He amt: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	'y)	20b. Place of D cemetery, Holy C1	coss Cer	neter	ry	10/3	0/2009		re,	Maryland
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Lice	amin adl	shi		Ritch	nie H	ighwa		imore,		land 21225
	Physician /Medical Examiner		23a. Part 1. Enter the disease of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Metast	11	bludd			cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
■ × 09289	ficate be executed physician and s the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of)								
O. Box 687	ath certi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 □ Fetal death at time of death	3 ☐ Ectopic pr 5 ☐ Other (sp					23d. Date Mor		ery Day Year
ds, P.	uires that the de isigned by the a d be detached f		Part II. Other significant conditions	contributing to death	, , , , , , , , , , , , , , , , , , ,		-					/	re cause of death? pably 4 ☐ Unknown
of Vital Records,	e law requir has been s je 2 should	Completed by	& ludder c	urer						24a. Was an autopsy perform	/	Vere auto	psy findings available mpletion of cause of
tal	sician: The certificate h rector, page	0	25. Was case referred to medical					26 Place	of Death		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	□Yes	2 No
f Vi	G.S. X	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 ER/Outp	atient 3 D0	Otho	۲۰		ne 5 🖪 Reside		er (Specif	y)
	ng ine	Certification:	27. Manner Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be		ay, Year) Inju	iry M		at ? 'es 2 □ l	No	28d. Describe ho			
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	building, e	ijury - At home, farm			no data s		28f. Location (Str City or Town	, State)		
	n 24 hc he Fun	Medical		nysician: To the bes miner: On the basis and manner s	of examination and/	or investigation,	in my op	ie, date an binion, dea	u prace, th occurr	ed at the time, da	ause(s) and ma ate and place, a	and due to	the cause(s)
	To the comp	M	29b. Signature and title of certifier	١.,		290	License	number		29	9d. Date signed	(Month,	Day, Year)
			20. Name and address of passes with	completed across =	death (Itom 22a) (T	(no Print)	999	040	1		10-28	- 9	009
	4		30. Name and address of person who	completed cause of	ueath (item 23a) (Ty	rpe, Frint)	1	O \	7		۸۸ -	2	

Registrar

State

State of Maryland / Department of Health and Mental Hygien 9 1 9 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 119 10 09 TVin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner If Under 1 Year Hours Min. S. Date of Birth (Month, Day, Year) elabilitation Extender Care 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign **Funeral** 1**X**M 2□ F 215-22-0106 83 Yrs MARYLAND Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 TYPes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21224 443 ELRINO STREET filed within 72 hours after death v Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married Married tyTyYes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2\times No Specify: Completed by 3 Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RIGGER ERECTOR SHIPBUILDER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any lighty or other traumatic event, DRB. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GRUPP KRATZ CHARLES ELSIE ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 443 ELRINO STREET BALTIMORE MD 21224 JEAN RUTH GRUPP/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX remation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 10/30/2009 GLEN BURNIE MD 22. Name and Address of Facility
CHARLES S. ZEILER &
6224 EASTERN AVENUE 21. Signature of Funeral Service Licenses ON, INC. BALTIMORE MD 21224 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. Immediate Cause (Final **Physician** Dementia 401 Known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to ministrate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of): Examiner ysician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ise as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signé 1 be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 34359 (OHIO) 6. MO 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) 3500 Loch Raven Boulevaird, Baltimore, Maryland 2/2/8 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Barks Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jessie Hardy October 22, 2009 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 2, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🕅 F 88 Scotland 220-50-7937 1921 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show if than "natural", or items 23a or 28a-f show the Medical Exprimer must be notified at 1 ☐ Yes 2 X No Directo Florida Citrus Homosassa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8130 West Windhaven Place 34448 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event, the Machelle sonce. Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>م</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Alexander Stuart 2 Jessie Isabella Porter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Stuart (Niece) 15826 Cedar Elm Terrace, Land O' Lakes, FL 34638 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan 10/28/09 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Ineral Service License 22. Name and Address of Facility
Hooper Funeral Homes & Crematory un Dunn W. Main St., Inverness, FL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardio-Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Respiratory Failure Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence offi The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Aspiration Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐Yes 1 ☐Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 🔀 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60936 October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul M. Tak, M.D. 7300 Van Dusen Rd., Laurel, MD 20707 31. Date filed (Month, Day, Year) Pigisaer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Norman 2.00 A M Hayes October 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year Months Days Hours 1 □ M 2 □ F 540-24-6059 Pennsylvania Director 14, 1919 89 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 No Silver Spring Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 3160 Gracefield Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 41 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give 1941 Year or Dates: 1946 1 ☐ Yes 2 ☑ No þ Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Forester Rubber Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental ပ Norman Hayes Virgie Alice Porch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Immerman - Daughter 5401 Nibud Court, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Mt. Pleasant Cemetery 10-26-09 4 ☐ Donation 5 ☐ Other (Specify) Mt. Pleasant Twp., PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vincent V. Rodgers Funeral Home J 805 Pennsylvania Ave., Box 488, Irwin, PA 15642 232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tran Due to (or as a consequence Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 TYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation spital or Attendi ours after death. heral Director: A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



59524

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 19a per fh 889/11-3-09 vt
State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner SECOL IRS TIM 5. Social Security Number If Under 1 Year | If Under 8. Date of Birth (Month, Day,) 01 29 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Min. Year) 1 □ M 2 □ F Days Hours 217-80-3014 Director 48 NC 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Widdles Examinar must be nothed at Director 1 Tyes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 North Smallwood Street 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐Yes 2 No Specify. à Specify: Black Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Private Housekeeping llth grade na filed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Turner Ernie Keel 19a. Informant's Name/Relationship (Type. Print)
Renie Hudgins—Daughter 19b. Mailing Address (Street and Number or Hural Houte Number, City of Johnson 11 North Smallwod Street, Baltimore, Md 21223 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 11/2/2009 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Signal vre of Funeral Service Licensee amald U. Md 21215 3a. Part r. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s .ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ULMONAR **Physician** MEEK /Medical Due to (or as a consequence of): Examiner DIOPATHICO cause the same that is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed and burial-tra Due to (or as a consequence of): Box 68760, physician requires that the death certificate be Physician/Medical the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 📈 No P.O. detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, β 2 No 1 ☐ Yes 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 2 No 1 Yes 2 □ No 1 Yes Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 determined 4 Homicide ŏ To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WOMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 LIFOM

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, OCT 3

() 2009

82. Registrar's Signature

Division within 24 hours after To the Funeral Dire State Registrar

DHMH 17 Rev 1/2001

29a. Certifier 1

29b. Signature and title of certifie

Pamela E. Southall, MD

Assistant Medical Examiner 31. Date filed (Moffile Cay) gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 25, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician EQUI 503 Harris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Examiner r of Under 24 Hrs. 1 MCD Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, If Under 1 Year Security Number (In yrs. last birthday) Age **Funeral** Days Min 1 M 2 □ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the "Actical Examiner must be in titled at 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 ☐ No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify þ 3 ₩ Widowed 4 Divorced lack Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) umhe 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Route Number, City or Town, State, Zip Code) 21132 Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural 19a. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses S 23a. Pan J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** shenmin e /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 ☐ Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122-8hu 32. Registrar's Signature 31. Date filed (Month, Day, Year. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b.c, 16a, perFH, 6896, 10/30/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 34822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 9:12 PM M Jack D. Hewitt, Sr 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Towson Baltimore Stella Maris Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F Months Hours Min 12709/1935 Director 215-32-7888 73 Tennessee Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Joppa_ 10d. Inside City Limits Director Harford 1 Yes 2X No MD **Baltimore Magnolia** 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 1017 Old Mountain Road - North 21085 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give marked other than "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) S & S Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Baltimore Co. Schools 8 - GED Driver and Mechanice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Milton McDowell Hewitt Allie Irene Craighead 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Nancy J. Hewitt (wife) 1017 Old Mountain Road - North - Magnolia, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Defeated Creek Mem.Gd:11/01/2009 | Carthage, Tennessee at re of Funeral Service Licensee 1g 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. HO Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final CEREBROVAS Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) g physician and is the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown of Vital Records, P.O. sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy perform prior to completion of cause of death? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Watural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes Division Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 15 ess of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

27,2009

OCTUBER

JACK

			1 - State Registrar	e of Maryland / Depa <i>Cel</i>	artment of Health and M rtificate of Death	Mental Hygi	ene 2009	3482		
	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death		
	/Medi		Martha Hunt				25,2009	1230 A		
1	Examir	ner	4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, or Location of Death		4c. County of Death			
	Funeral		Casey House 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery	I blace (State or Foreign		
	Director		240-34-7446 1□M 2₺		Months Days Hours Min.	8. Date of Birth (Month, Day, August 1	Year) 1921 Loui	isburg NC		
	nd.		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo				0.1.1		
	f sho	ō						0d. Inside City Limits YYes 2 □ No		
	the N	rect	District of Columbia 10e. Street and Number	Washingto	10f. Zip Code	100	g. Citizen of What Cour			
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Exami	Ö	5060 13th Street NE		20017		Inited State			
	death	Funeral Director		Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Orlgin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ			
36	after , or it	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ If Ye	Yes 2X No s, Give	1 □Yes 2⊠No <i>Specify:</i>	rnican, etc.)	Black, White, Specify: Black			
Ö	hours tural"	Completed by		r or Dates:	dent's Usual Occupation	4,	6b. Kind of Business/Inc			
15	iin 72 n "na de lic	plet	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colli-	eted) (Give	kind of work done during most of work DO NOT use retired)	ing	bb. Kind of Business/inc	dustry		
212	d with giene er tha	E O	Twe1th Non	ege (1-4or 5+) e Homem:	aker	Р	rivate			
pu	be file tal Hy d othe	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma				
<u> </u>	ould I Men narke	ရ	William Thomas			Mitchell				
Mai	d2sh than :7isn traun	1 1	19a. Informant's Name/Relationship (Type. Prin Estelle Jackson/Daugh		ng Address <i>(Street and Number or Rui</i> 1 3th Street NE Wa			Code)		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Exprinit Part once.		20a. Method of Disposition	20h Place of Disno	sition (Name of		DC 20017 Oc. Location - City or To	wn, State		
m 0	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Harmony N	natory or other place) lemorial Octob	er 31, L	andover Mar	yland		
alti	permit. I Departm Importa any inju		21 Signature of Euparal Carries Licenses	Onald Gray	Name and Address of Facility Rob	ert G. M.	ason Funors	1 Uomo Ima		
Ω.	8 9 5 6	- 1	1 K.65	onard Gray	61 Good Hope Rd S	E, Washi	ngton DC200	20		
	Physician /Medical Examiner		23a. Party. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not ent				Approximate Interval Between		
100		Examiner	Immediate Cause (Final disease or condition resulting in cheath)	oticemia				Onset and Death		
			Due to (or as a consequence of):							
			Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):						
	cuted nd ransit		if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events c.							
oʻ	e exe ian ar ırial-tr	Exa	resulting in death) Last Du	ue to (or as a consequence of):						
8760,	cate be executed physician and the burial-transit	dical	d							
9	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23c If ve	s, outcome of pregnancy						
Вох	leath atter	Physician/Me	in the past 12 months?	Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year		
P.O.	that the deneded by the detached	hysi		Unknown						
	ires tha signed I be det		Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to th	ne cause of death?		
ord	w require s been sig should b	ted t	Hypertension			1 ☐ Yes	2 □ No 3 □ Prob	ably 4 🔀 Unknown		
ec	e law r has be je 2 sh	Completed by	Chronic Kidney Disease	2		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of		
E H	ician; The certificate h ector, page	Con				performe	ed? death? ☑No 1 ☐ Yes	2 X X0		
of Vital Records,	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	-	T045	h (Check only one)				
o	Phys arthis aral di	Certification: To	To res 2 25 NO	1 ☐ Inpatient 2 ☐ ER/Outpatier Date of Injury 28b. Time of	1 3 DOA 4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6x1Other (Specif	W Hospice		
Division	nding Path. r: After i e funera	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	Work? M 1 □ Yes 2 □ No		,,			
Vis	al or Attendi safter death. I Director: A d in by the fu	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.	Place of Injury - At home, farm, strobulding, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,		
ō	Hospital or Attending 24 hours after death. Funeral Director: After itely filled in by the fune	Cer	0			Only or rount,				
	ne Hospital on 24 hours aft ne Funeral Di pletely filled in	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/or in	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s te and place, and due to	tated. the cause(s)		
	To the Hosp within 24 ho To the Fune completely f	Mec	and	manner stated.	29c. License number	290	d. Date signed (Month,	Day, Year)		
	r × r o		J. Kou atche	u, mo	263748		October 29,			
			30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)		- ,			
			Jocelyne Kouatchou MD	6001 Muncaster	Road, Rockville M	D 20855				
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signature	unted					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR G896 10/30/09 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 34824 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **ESTHER HOFFMAN** 2009 9:20 AM 28 OCTOBER 4c. County of Death
WORCESTER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BERLIN NURSING HOME BERLIN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12 (Month, Pay Year) Birthplace (State or Foreign Country)
 NV 5. Social Security Number 7. Age (In yrs. last birthday) 1□M X F 95 Months Days Hours 218-07-8823 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State OCEAN CITY MD WORCESTER 1 ☐ Yes 妆 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21842 USA 121 CHANNEL BUOY ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No WHITE Specify. Specify: 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTY SALON MANICURIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **FOREMAN** JULIA FLITT MAYER rmant's Name/Relationship (Type. Print) DAUGLIER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 CHANNEL BUOY ROAD, OCEAN CITY, MD 21842 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 Removal from State 10/29/2009 BALTIMORE, MD ADATH YESHURUN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 e of Funeral Service Licensee Approximate Interval Between Onset and Death 23d. Date of delivery Year

Physician /Medical Examine

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 111 Medical Examinations to the rectified at

Baltimore, Maryland 21215-0036

HOFFMAN, ESTHER

Be Completed by Funeral Director

P

/Medical

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-trans

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	Examiner
	Completed by Physician/Medical
	Completed by
	Be Co
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	lication:

23a. Part 1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	or complicing on the control of the	cating that caused the death. e course on each line.	Do not enter the n	node of dying, such as cardi					
Due to (or as a consequence of): Sequentially list conditions, in any, teading to minimize date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown									
Part II. Other significant cond	itions con	tributing to death but not resul	iting in the underlyin	g cause given in Part I.	23e. Did tobacco u				
	·				24a. Was an autopsy performed? 1 □ Yes 2 No				
25. Was case referred to medi examiner?	-			,	eath (Check only one)				
1 Yes 2 No	H	ospital: 1 Inpatient 2 E	R/Outpatient 3 ☐	DOA Other: 4 Nursing	Home 5 ☐ Residence				
2 LI Accident	stigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur				
	ld not be rmined	28e. Place of Injury - At hor building, etc. (Specify	ne, farm, street, fac	tory, office	28f. Location (Street ar City or Town, State				
(Check only _ 2 Medic	ai Examir	sician: To the best of my knowner: On the basis of examination and manner stated							
29h Signatule and title of cert		TI BE CIETA		29c. License number	29d. Da				

23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N

				26	Place of Dea	th (Check only one)
Haspital:					ome 5 ☐ Residence 6 ☐ Other (Specify)	
1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how injury occurred
е	28e. Place of Injury - At he building, etc. (Special	ome, farm, street,	, factory, of	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, and due to the	ne cause(s) and manner as stated.
(Check only 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
one) 3 Cert Nine Pand manner stated		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Moune Sourage CRM	K135131	10/28/19

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennie Savage, CRNP, 106 Milford Ar, Suite 402 Salisbury, MD 21804

31. Date filed (Month, Day, 32. Legistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 34825 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Anne Elizabeth Haines 938 M 00 23,200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Maryland Director 219-20-4302 81 Oct 31, 1927 Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Director MD Carroll Westminster 1 ☐ Yes 2 ☐XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Saint Lukes Circle Funeral 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ev.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ed other than "natural", or event, the Medical Example 1 ☐Yes 2X No Specify: ģ Specify: white 3 Widowed 4x Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 16b. Kind of Business/Industry un (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygienn Important: If item 27 is marked other the amy Injury or other traumatic event, Inspect. receptionist 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Jessee Winterson Mary Anne Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Ann Smith/daughter 45 Timber Ridge Drive; Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Ronald S. Wood State Anatomy Board; 655 W. Baltimore Street Director ans Raltimore, Maryland 21201 Pal Filmore, Maryland 21201

Da. Par 1. Enter the ilsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirt, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final **Physician** where - proportion disease or condition resulting in death) SERVE 4 estres /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least to infine data cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Examiner Due to (or as a consequence ofly Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the detached 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed page 2 should 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown Laycerona 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an was autopsy performed? certificate 1 □Yes 2 🗆 No 1 ☐ Yes director, 25. Was case referred to medical 8 26. Place of Death (Check only one) atunt examiner? Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Teath e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 □ Yes 2 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 0 8.8 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 295 cot 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>	ealth and M Death	lental Hygi	ene 2009	34826
	Physici /Medic		Decedent's Name (First, Middle, Last)	Wayne Cliftor				2. Date of Death Month October	n Day Year	3. Time of Death 6:20 P. M
	Examir Funeral Director		4a. Facility Name (If not institution, give 408 Annabelle Av. 5. Social Security Number 213 52 1297	enue	. last birthday) Yrs.	**	Location of Death timore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/08/	Year) Con	nplace (State or Foreign untry) ryland
	ס	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. C	ity, Town or Lo			10/00/	1747	10d. Inside City Limits 1 ☑Yes 2 ☐ No
	th with the 23a or 28a ast be notif	al Director	10e. Street and Number 408 Annabelle A	venue		10f. Zip Code	1225	1(Og. Citizen of What Co.	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Eventine must be notified at	by Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 🛣 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	within 72 ho jiene. r than "natui the Medicul	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10th	cation e com <i>pleted)</i> College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired D Driver	ation luring most of worki)	ng	16b. Kind of Business/IBaltimor	
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event event aumatic event ev	To Be C	17. Father's Name (First, Middle, Last)	George Hadawa	у		18. Mother's Name Mar	y Lou E1		
	ges 1 and 2 should I t of Health and Men If Item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (7) Tabatha Johnson	/ niece	1104	Laurens	Street	Baltimo	City or Town, State, Z	nd 21217
Baltimore,	t. Pages rtment o rtant: If rjury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Ba	yview (sition (Name of natory or other place Crematory 2. Name and Addres	10/2	9/2009	Baltimore, eral Service	Maryland
B	permi Depar Impo any ir		23a. Part 1. Enter the disease, or emploshock, or heart failure. List only o	ramerous	ski !	4001 Ritc	hie Highw	ay Balt	imore, Mar	yland 21225 Approximate Interval Between Opset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	quarce of):	new	-			Jonost (
68760, 24	icate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consec						
.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1	al death 3	Ectopic pregnancy	1		23d. Date of del Month	ivery Day Year
ords, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions co		sulting in the ur		en in Part I.		es 2 No 3 Pr	the cause of death?
of Vital Records,	slcian: The law re certificate has be irector, page 2 sho	Completed	- Hyperi	produc-	-			24a. Was ar autops perforn 1 □Yes 2	y prior to death?	topsy findings available completion of cause of 2 □ No
of Vita	> .02 73	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mannus Ceath	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier	other	26. Place of Death	me 5 Reside	ence 6 Other (Spec	city)
Division	To the Hospital or Attending Phy within 24 hours atted death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	(Month, Day, Year) 28e. Place of Injury - At he building, etc. (Special Control of the Control	Injury nome, farm, str	M 1 🗆	Yes 2 □No		w injury occurred reet and Number or Ru , State)	ural Route Number,
	n 24 hours n 24 hours le Funeral	Medical C		sician: To the best of my kn ner: On the basis of examin and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	- MD		29c. Licenso	s number	29	9d. Date signed (Monti	/
	7		30. Name and address of person who co	ompleted cause of death (Ite	Defee.	Print) Theet	Blom	ne p	Conford	21225
	Sta Registr		OCT 3 0 2009	Server S.	park					

			1 - For State Registrar	State of Marylar	•	artment of F rtificate of I		fental Hygie	ne No.2009	34827
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	/Medio Examin		4a. Facility Name (If not institution, giv		HOLI		r Location of Death		4c. County of Death	2:25 A ^M
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	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year	I Under 24 Hrs.	8. Date of Birth	Baltimo 9. Birthp	lace (State or Foreign
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	irylar ihow	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			1	0d. Inside City Limits
	Ba-f s	Director	Maryland Baltim	ore	Tows	on				1 ☐ Yes 2 📉 No
	or 28	Ë	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	try?
	23a ust b	-	615 Chestnut	Avenue		212	04		U.S.A.	
	r deg	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
စ္	d within 72 hours after death with the Maryland glene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Fi	1 □ Never Married 2 □ Married	No lives, Give Year or DatesWWII		1 ☐ Yes 2 【X No	Specify:		Specify:	
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	2 should and Men is marked aumatic	ř	19a. Informant's Name/Relationship (na Address (Street a			erson ty or Town, State, Zip	Holler
Mar	and 2 sealth ar		Gloria Bryan	Daughter	1			thicum, M	•	1090
ā,	ーエッキ		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	t		. Location - City or To	
5	Pages nent of h int: If ite		1 ☐ Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Special	Removal from State	-	natory or other plac	i i	2000		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
saitimore,	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service lices	12100	setawn 22	BUT1AL Pa	SS of Facility Day	-2009 Mar	tinsville Funeral H	virginia
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear					yland Ziz	Approximate Interval Between
	Physician	0.0	Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. PAILUX Due to (or as a consec	E to	INTIVE			-	6 months
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X Q Q	th ce tendil r use	sician/Me	23b. Was decedent pregnant	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of delive	·
	ed for u	sici	in the past 12 months? 1 ☐ Yes 2 🛣 No	4□Pregnant at time of o		Other (specify)			Month	Day Year
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	slcian: The law s certificate has b lirector, page 2 s	5	Dementra					performed 1 Yes 2 1	? death?	
VIII V	sian: ertific ctor,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
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	ding Phys		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at	28d. Describe how it		
Uivision	Attending ir death. ector: After by the fune	Certification:	2 ☐ Accident investigation			M 1 []	Yes 2 □ No			
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2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		20 0 111							
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	the the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. License				
	J. W. D. O.		200. Organitate and time of Certifier	77-					Date signed (Month,	
is	21		Kroneks	~ /m		Ro	79544	6	0/29/2	005.
19	ハノ		30. Name and address of person who	/ /		Print)		Da 11	10/29/2 .mo 2.	1204
2	-C1		31. Date filed (Month, Day, Year)	6 \$65 Ki, Ci	HARLE T	31. 272	4105	IONDON	, my d	/
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State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10/29/2009 Anthony Joseph Iacoboni, Sr. 5:03 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 6/8/1929 Months Days 1 □XM 2 □ F Director 217-26-8858 80 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Madical Examination must be notified at 10d. Inside City Limits Kent Stevensville Director 1 ☐ Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Harward Lane 21666 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ NO ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Contractor other than Elementary/Secondary (0-12) College (1-4or 5+) Utility 12 17. Father's Name (First, Middle, Last) i. Pages 1 and 2 should be fili thent of Health and Mental H rtant: If Item 27 is marked oth ijury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Camillo Iacoboni Anna DeNicolis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 Harward Lane Stevensville, MD 21666 permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Nancy Iacoboni / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Mother (Specify) Entombment Corraine Park 11/2/2009 Baltimore, Maryland 22. Name and Address of Facility TOWSON, Maryland 21204 21. Signature of Fungral Service Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final . Physician KIN /Medical resulting in death) Due to (or as a consequence of): Examiner Vertebral if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Year 4 Pregnant at time of death Day 5 ☐ Other (specify) 1 □Yes 2 □ No detached 9 T Hoknowa signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2NZ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check only one) within 2: To the F 29b. Signature and D0060225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 medical Parhway Annapolis, Mel 21401 ETTE TEVE 31. Date filed (Monta State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 5:36PM 2009 01 23-4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ochern Fusire core Baltimore ton Manor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Hours Days Months 1 X M 2□ F 95 1944 212-42-0025 15 laryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No rangland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4800 212 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No. If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BUACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+harade Supervisor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ances Lones LOSCON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (ne ice) 444 DoiField ave, Baltimore, MD 21215 lamata Alckander 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/2001 Battimes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) memorial Park 22. Name and Address of Facility JR. Funeral Home 21. Signature of Funeral Service Licenses ZIMON. Fulton AVE BOLLIMONE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 year onan disease or condition resulting in death) Due to (or as a consequence of Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

and

cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran

certificate

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After 1

within 24 hours after death
To the Funeral Director:
completely filled in by the

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Physician/Medical

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Certification: To

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/Medical

Examiner

Funeral

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28a-f show

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Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Director

Funeral

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Completed

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Department of Health and Mental Hygiene. Important: if item 2.2s or 28a-f show any injury or other traumatic event, the Macinal Every increases the source once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

1 Inpatient

25. Was case referred to medical examiner? Be 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be

Hospita!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of Injury

2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

BALT

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check onl. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Metical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and tipe of PHYSIC 29c. License number P002d014

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date file (Month, Day, Year) 30 2009 WASHINGTON BLUD-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2, per MD g89/11/4/09 TII Certificate of Death

Reg. No. 34830 1 - For State Registrar Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Janice Jones Physician 4: 20A M 2009 ania /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore evindale If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🙀 F 81 Yrs Director 215-24-7700 03 13 GA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Show 10b. County at Y☐Yes 2☐No d 2 should be filed within 72 hours after death with the Man th and Montal Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notifiled. Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1006 North Rosedale Street 21216 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Stanlev Home Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Products Sales Leader 'na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Mae Maxwell Johnnie White ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 A Oak Grove Drive, Middle River, Md Janice Jones-Daughter Health a item 27 other t 20c. Location - City or Town, Stat 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Department of Important: If its any injury or o once, Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 10/30/09 Cedar Hill Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ediate Cause (Final Isease or condition resulting in death) **Physician** Dementlo /Medical Due to (or as a consequence of): Examiner ulmonaru Sequentially list conditions, Due to (or es a consequence of) Examiner rany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown s been signed by the should be detached σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 1 ☐ Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1□ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide ь within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title dress of person who completed cause of death (Item 23a) (Type, Print) 30 Name and a 2424 West Belvedere Avenue Sayed 0 21216 31. Date filed (Month, Day, 32. Registrar's Signature State rack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Deçedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 009 Ò ones /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Itimore Muspital GUERC 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 M 2 □ F Days Hours Min. 20 12 - 456 ual Residence of Decedent Director irginia Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 0d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov 1 Nes 2 No **Funeral Director** MOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unt 12. Was Decedent Ever in U.S. Armed Forces? 1 IV fes 2 □ No If fes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) parrous Elementary/Secondary (0-12) College (1-4or 5+) Yes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Ments Important; If Item 27 Is marked any Injury or other traumatic ev ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 381 Back, MD 2123 DOYO ynden 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State When the VCT, Con. 22. Name and Address of Facility 4 Donation 5 ☐ Other (Specify) MOWASVIlle 21. Signature of Fy neral Service Licensee 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPS15 /Medical Due to (or as a consequence Examiner atera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 XYes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation thours after death. death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Partsille MD 21239 JIGAR Site 201 Registrar's Signatur Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar 32.

09-07700 Donnell Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Maryland & Department of Hearth and Mental Physiches JH

2009 34832

		1- For State Certificate	of Death	Reg	J. No.	0400
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	. Time of Death
ledical Examir		Donnell Johnson	T	October 4,	2009	0941 hrs
	П	4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Dea Baltimore	tn	4c. County of Death	
Funeral		5. Social Security Number Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthp	lace (State or Foreign
Director		210 70 0113	Yrs. Months Days Hours M	ın. I	Ocui	11and
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lor	cation		1	0d. Inside City Limits
* "		MD Anne Arundel Glen	Burnie			1 Yes 2 No
faryland 28a-f show Lat once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Countr	y?
th the Maryland 23a or 28a-f sho notified at once.		200 Plymouth Lane #B	21061		USA	
be a	₫ l		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		14. Race - America White, etc.	n Indian, Black,
ter dea	Fun	1 Yes 2 X No	Yes 2 X No specify:		Specify: bla	ck
ours af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kind o	f work done	16b. Kind of Business/Inc	
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21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medica	Comple	<u>unk</u> 12 <u>unk</u> 1	Manager 19 Methods No.	ne (First, Middle, M	hidan Surnama)	
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212 ould bould by Ment	10 E	Leon Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	iling Address (Street and Number of 053 Greenleaf Ter	James or Rural Route Num	ber, City or Town, State,	Zip Code)
MD d 2 shc lith and n 27 is		Sharon Sales /sister H	Penn Street Bal	timore,	4D 21201	21061
s 1 an of Hea If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or	position (Name of cemetery, r other place)	Date	20c. Location - City or To	own, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 X Other Specify: in state				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	ļ	Ronald S. Wad Mirector S	2. Name and Address of Facility tate Anatomy Boa altimore, MD 21:	rd 655 W.	Baltimore	Street
Physician		23a. Part Enter the disease or comblications that caused the death. Do not enter failure, List only one cause on each line.	er the mode of dying, such as cardiar	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Chrise (Final disease a. Narcotic intoxicat	ion			Death
, i		or condition resulting in death) Due to (or as a consequence of):				
	ie l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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8760, ificate be up physici	₹	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic prec	nancy	23d. Date of delivery Month Da	y Year
Box 687 ne death certifi the attending	Physician	4 Pregnant at time of death 5	Other (Specify)			3
. BC he dea y the a	چُا	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I	23e Did to	bacco use contribute to the	e cause of death?
i, P.O. ires that the signed by I be detach	<u>a</u>	Cardiomegaly, morbid obesity	te directlying cause given in rait i.		2 No 3 Proba	
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COF e law r e has b	nple.			_ autops perfor	med? death?	mpletion of cause of
tal Recol		25. Was case referred to medical	26.Place of Death (Che	1 Yes 2	2 No 1 ✓ Yes	2 No
Vital Rec ysician: The his certificate director, page	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpati	iOther:		Residence 6 Other:	
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trendi Heath.	aţio	Natural E	353 hrs 1 Yes 2X No	unk		<u> </u>
Division of Vital Records, tat or Attending Physician: The law requir rs after death. Al Director: After this certificate has been sted in by the funeral director, page 2 should!	Certification:	3 Suicide 6 X Could not be determined (Specify) Tesidence		28f. Location (S	Street 200 Plymou Late 200 Plymou Len Burnie,	Poute Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit.		29a. Certifier				
o the Fithin 2, or the Fi	edical	(Check only one) 2 Medical Examiner: On the bast or my knowledge, cearn or any and manner stated.	igation, in my opinion, death occurre	d at the time, date	and place, and due to the	cause(s)
F 3 F 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		(alssasta)	O.C.M.E.		October 5, 2009	
		30. Name and address of person who completed cause of death (Item 23a)	Ponn Stroot Politimore MD	21201		
	ate	A	Penn Street, Baltimore, MD	Z 1ZU I		
St Regist	ate	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SN/Stell			

09-08332 Gary Knight, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 34833

		For State	Certific	ate of L	Death		F	Reg. No.	
Physician	/ 1	Decedent's Name (First, Middle,Last)	Knight	Sr		-	2. Date of De Month October 2	ath Day Yea	3. Time of Death 1245 hrs
		Gary a. Facility Name (if not institution, give street and		4b	. City, Town, or L	ocation of D		4c. County of	of Death
Funcion	,	Union Memorial Hospital Social Security Number 6. Sex	7. Age (In yrs. last bir		Baltimore If Under 1 Year	If Under 2	4Hrs. 8. Date of B	irth(MM/DD/YYYY	9. Birthplace (State or
Funeral Director		095-54-1219 _{1XM 2} F	50	Yrs.	Months Days	Hours	14:-	1959	Foreign Country) MD
any	_	sual Residence of Decedent Oa. State 10b. County	10c. City, Town	or Location	n				10d. Inside City Limits
*	<u>.</u>	MD N/A	Balt	imor					1 X Yes 2 No
a or lifted		De Street and Number 2748 Fenwick Avent	ıe		10f. Zip Code 212	18		10g. Citizen of Wh	
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hours "natur		15. Decedent's Education (Specify only highest gr Elementary/Secondary (0-12) College	rade completed) 16a. (1-4 or 5+)		Usual Occupations of working life. I				more City
5-0036 lied within 72 hours Hygiene. I other than "natur the Medical Ex. m		llth grade	n/a	Sani	tation				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygene. Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. To Be Commissed by		7. Father's Name (First, Middle, Last) James Knight			. 1		Name (First, Middle Dara Cro)
b 21 should and Mer	2	9a. Informant's Name/Relationship (Type, Print)	- 1	-	•		r or Rural Route No 7enue Ba		m, State, Zip Code)
e, MD I and 2 sho Health and item 27 is		Yvette Watson-daug	20b. Place	of Dispositi	on (Name of cem	etery,	Date	20c. Location -	- City or Town, State
Baltimore, oermit. Pages I an Department of Hes Important: If iten injury or other tr	1	XBurial 2 Cremation 3 Removal Donation 5 Other Specify:	WOO	dlawr	n Cemet		1-3-200		
Balti permit. Departr Import	T	1. Signature of Funeral Service Licensee			me and Address			East F/ e Balt	07000
Physician	+	3a. Part I. Enter the disease, or complications tha failure. List only one cause on each line.	caused the death. Do n	ot enter the	mode of dying, s	such as card	h Avenu liac or respiratory a	rrest, shock, or he	
/Medical Examiner		mmediate Cause (Final disease a. Atherosc	erotic Cardiovascus a consequence of):	ular Dise	ase				Death
		Sequentially list conditions, b	s a consequence of):						
ted nsit		Disease or injury that initiated c.							6
uted 11d ransit		events resulting in death) Last Due to (or a	s a consequence of):						
ficate be executed g physician and sthe burial - transit		UNPENDED AMENDE							
18760, rdificate be ing physic as the bur		Bb. Was decedent pregnant in the		/ 2 Feta	ıldeath 3	Ectopic p	regnancy	23d. Date of Month	f delivery Day Year
Box 68 e death certif	Pnysiciar	Vac of No of Heknows 4 Pre	gnant at time of death known	5 Othe	er (Specify)				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	y P	Part II. Other significant conditions contributing	g to death but not resulting	ng in the un	derlying cause gi	ven in Part			ribute to the cause of death? Probably 4 ✔ Unknown
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Physic Physic eral dire	의	1 Ves 2 No 28a Da	Inpatient 2 V ER/0	Outpatient Time of Inj	0 Jon	other ₄ n y at Work?	Nursing Home 5 28d. Describ	Residence 6 e how injury occur	Other:
ion c tending eath. or: Aft the fun		1 Natural 5 Pending 2 Accident Investigation	nth, Day, Year)		1□ Y	es 2 N			
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the and red feath. The rectors After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined (Special Suicide Suicide Could not be determined (Special Suicide	lace of Injury - At home,	farm, street	, factory, office be	uilding, etc.	28f, Location or Town		per or Rural Route Number, City
	Medical C	9a. Certifier 1 Certifying Physician: To the check only 2 Medical Examiner: On the bas	is of examination and/or	eath occurre	ed at the time, da	te and place death occu	e, and due to the ca	use(s) and manne te and place, and	er as stated. due to the cause(s)
To To com	ĭ Mec	and manne	er stated.		29c. License				ned (Month, Day, Year)
		(Mess			O.C.N	И.Е. 		October 2	8, 2009
71		30. Name and address of person who completed of Ana Rubio MD. Assistant Medica	al Examiner 111		reet, Baltimo	re, MD 2	1201		
Sta Registra	œ	31. Date filed (Month, Day, Year)	Rigistrar's Signature	ha	plant				
DHMH 17 Rev 1/200		001 = 0-5000-1/C	0	RIGINAL					

			For State Registrar	State o	f Maryland /	Depa <i>Cer</i>	rtment of F tificate of	Health <i>Death</i>	and Me	ental Hyg	leg. No. 20	09	34834
	Physicia		Decedent's Name (First, Mid Maxy		ennerly					2. Date of Dea Month October	Day	Year	3. Time of Death 2:23 P M
A.	/Medic Examin		4a. Facility Name (If not institut				4b. City, Town, o	r Location		200001	4c. County		1=.23
-	LAUIIIII		Frederic	k Memorial	Hospital		Frede	erick			Fr	eder:	ick
	Funeral Director		5. Social Security Number 212 32 0486	6. Sex 1 □ M 2√2 F	7. Age (In yrs. last b	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Vovember	20°1934 E	9. Birthp Baltin	lace (State or Foreign ltry) ore Maryland
	D		Usual Residence of Decedent						1				
	urylan show	_	10a. State 10b. Coun		10c. City, To		cation					1	0d. Inside City Limits
	Ba-f	Director	Maryland Carro	<u> </u>	Taneyt	cown							1 □Yes 2√□No
	a or 2	Dir	10e. Street and Number 412 Clubside Driv	10			10f. Zip Code 2178	17			10g. Citizen of W USA	nat Cour	itry?
	leath ns 23	Funeral	11. Marital Status		edent Ever in U.S.	13. V	Vas Decedent of I	Hispanic O	rigin? (Spec	cify Yes or No-		- Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, In Medical Evanting in the Indifficult and once.	by Fur	1 Never Married 2 M	Armed Fo arried 1 ☐ Yes If Yes, Gi	orces? 2421 No ve	. 1	fYes, specity Cub □Yes 2 XX No	an, Mexica Specify	n, Puerto R	lican, etc.)	Black Specify.	ر, White, ر	etc. ite
9	houn tural	ed b	3 ☐ Widowed 4 ☐ Divorce	ed Year or Dent's Education		Sa. Decec	lent's Usual Occu	nation			16b. Kind of Bu	11.00	
215	iin 72 ii. in "na	plet	(Specify only high	nest grade completed)	1.40×5.\	(Give life. L	kind of work done OO NOT use retire	during mos d)	st of working	g			
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Baltimore, Maryland 21215-0036	d be file ental Hy ced oth	Be (17. Father's Name (First, Middle Charles Maximill:					18. Moth			Maiden Surnam	9)	
7	should nd Me mark matic	ပ	19a. Informant's Name/Relatio		15	9b. Mailin	g Address (Street				r, City or Town,	State, Zip	Code)
, Ma	and 2 sealth ar		Karen Hunt (Daugh		1	170 Ri	ver View T	rail			. 21784		
ore	ges 1 at 1 of He lif iten		20a. Method of Disposition Burial 2 Cremation	n 3 □ Removal from	20b. Place cemes	of Dispo tery, cren	sition (Na <i>me</i> of natory or other pla	ce)	Da		20c. Location -		
tim	t. Pag rtment rtant: njury		4 □ Donation 5 □ Other	(Specify)	Dulane		ley Memori	· · · · · ·			Baltimore,	Mary1	and
Ba	permi Depar Impor any ir		21. Signature of Funeral Service	ce Licensee	2	La 74	. Name and Addre ISSA hn Func 101 Belair	eral Ho Road	me Inc Baltim	ore Mary:	land 21236	ò	
			23a. Part 1. Enter the disease, shock, or heart failure. L	or complications that out only one cause on	caused the death. Deach line.	e not ente	er the mode of dyi	ng, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Between
34	Physician		Immediate Cause (Final disease or condition	ء و	nd ste	19-	e en	nphi	152	ma			Onset and Death
- Marie	/Medical Examiner		resulting in death)	Due to	(or as a consequence	eop			7				
		er	Sequentially list conditions, if any, leading to immediate	b	(or as a consequenc	e of):							
dr	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1									
Pa	e exec ian an ırial-tr	Exa	resulting in death) Last	Due to	(or as a consequenc	e of):							
38760,5	ficate be executed physician and s the burial-transit	dical		d									
9	certific ding p	/Mec	IF FEMALE:	220 If you ou	tcome of pregnancy								
Box	eath certii attending for use a	cian,	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fetal dea		Ectopic pregnand Other (specify)	су			23d. Dat Mo		ery Day Year
0	t the d by the tached	ysid	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unki		. 3	Joiner (Specify)						
Э.	ding Physician: The law requires that the death cer. An. furer this certificate has been signed by the attendin funeral director, page 2 should be detached for use	by Physician/Me	Part II. Other significant cond	itions contributing to d	eath but not resulting	j in the ur	nderlying cause gi	ven in Part	l.	23e. Did to	bacco use contr	ibute to t	he cause of death?
Division of Vital Records,	equire en sig ould b	ed b								1/2(v	es 2□No	3 ☐ Prol	oably 4 Unknown
ec C	e law re has be ie 2 sho	Completed								24a. Was a		Vere auto	ppsy findings available mpletion of cause of
<u> </u>	The ate h	E C								perfor	med2 c	leath?	
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medie examiner?		,				e of Death	(Check only or	ne)		
of \	Physi this o		1 Yes 2 No		Inpatient 2 ER/		it 3 DOA				dence 6 Oth	(-1	fy)
n	ding F	ion	27. Manner of Death 1 Natural 5 □ Pendings	ding (Mor	of Injury 28b th, Day, Year)	. Time of Injury	Wo	ryat rk?]Yes 2 ⊑		8a. Describe n	ow injury occurr	ea	
isi	death death ctor: y the	ficat	3 ☐ Suicide 6 ☐ Coul	1	e of Injury - At home, ing, etc. (Specify)	farm, stre		1163 2 6		8f. Location (S	Street and Numb	er or Rura	al Route Number,
Ö	tal or / rs after al Dire	Certification: To	4 Hornicide							City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after feath. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)	ying Physician: To the al Examiner: On the b and mar	e best of my knowled basis of examination oner stated.	lge, death and/or in	n occurred at the t vestigation, in my	ime, date a opinion, de	and place, a eath occurre	and due to the ed at the time,	cause(s) and ma date and place,	anner as a	stated. o the cause(s)
	Fo the within Fo the somple	Me	29b. Signature and title of certi		. /		29c. Licen	se number			29d. Date signed	d (Month,	Day, Year)
			1	> Ne	- Na		mn	トスト	100-		10/3	23/	12009
	15		30. Name and address of pers	on who completed cau	se of death (Item 23a	a) (Type,	Print)	2.0	-		L		2009
			myung	tee na	m 400	M	2St 7#	1 37	. tre	ederi	ck, m	D. 6	1071
	Sta Registr		31. Date filed (Mosth - 200)	9 across	registra s Signature	A Comment					•		

			For State Registrar			f Marylaı	-	artmer			and M	ental Hy	giene Reg. No.	HHY	348	35
	Physici		1. Decedent's Name Kenneth	e (First, Middle, La Franklyn	**** Kirgan							2. Date of De Month	Day	7 26719	3. Time of D	Death
0	/Medi Examir		4a. Facility Name (I.		ve street and nui	mber) tospit	al	4b. City,	Town, or	403	e da l	le	4c. 0	County of Death	imon	e
	Funeral Director		5. Social Security N 214 54 562	25	Sex Ny⊒M 2□F	7. Age (In yrs 58	. last birthday, Yrs.	Months	r 1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bi (Month, D Septemb	rth ay, Year) er 24	9. Birth 1951 Balt	place <i>(Ŝtate or</i> intry) Imore ,Mai	Foreign cylanc
	aryland show	_	Usual Residence of 10a. State	10b. County			ity, Town or Lo								10d. Inside City	
	the Mark	recto	Maryland 10e. Street and Nur	Baltimore mber	!	Bat	timore C		p Code				10g. Citiz	en of What Cou	1 ☐ Yes :	
	tth with 23a or ust be	ral D	7426 Kenlea	a Avenue					2123	6				USA		
5-0036	be filed within 72 hours after death with the Maryland ntal Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Medical Expressor.	d by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Married	12. Was Dece Armed Fo 1 ∐Yes If Yes, Giv Year or D	ve	i i	Was Dece If Yes, spe 1 □Yes		ispanic Ori in, Mexican Specify:		cify Yes or No Rican, etc.)		4. Race - Amer Black, White, Specify: Whi	etc. te	
5.5	in 72 h n "natu	Be Completed		15. Decedent's E	ade completed)		16a. Dece (Give	edent's Usu e kind of wo DO NOT u	ial Occupi ork done d ise retired	ation <i>luring most</i> l)	t of workin	g	16b. Kin	d of Business/ti	ndustry	
212	ed with ygiene ver th a	Com	Elementary/Second 12		College (1	-40r 5+)	Agent						<u> </u>	opolitan	Insurance	∋ Co.
yland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the man and the man a	To Be	James Kirga		t)						er's Name yn C W	(First, Middle filson	, Maiden S	Surname)		
Ken neth Baltimore, Maryland 21	es 1 and 2 should b of Health and Ment f item 27 is marked r other traumatic e		19a. Informant's Na Brandon Jan					ing Addres: Torey				Route Numb Ma rylan		Town, State, Z. 9	p Code)	
2.7 lore,	Pages 1 and the tot the tot the tot the tot the tot the tot the try or other	8	20a. Method of Disp 1 ☐ Burial 2 🖁	position Cremation 3 [Removal from		Place of Dispo cemetery, cre					ate		ation - City or T		
at in a	permit. Pages Department of Important: If it any Injury or o			5 ☐ Other (Speci	ify)	Me	tro Cren			Uctope: s of Facilit ral Ho			Baltı	more,Mary	tand	
ä	m Deg		I CON	toe De	30hn (20						; ire,Mary	land 2	1236		
Ist.	Physician and physician and the buriat-transit	Examiner	23a. Part1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death) Sequentially list contains to the cause. Enter Under Cause (Disease or that initiated events resulting in death).	rt failure. List only (Final In Inditions, I collaterlying Injury	a. Due to (aused the deal ach line.	quet a of):	nia	Sul		cardiac or	respiratory a	arrest,		Approximate Interval Betw Onset and D	veen eath
P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1	months?	4 ☐ Pregr 9 ☐ Unkn	birth 2 Fet nant at time of own	al death 3[death 5[□ Ectopic į	pecify)			220 Did		3d. Date of deliment	Day Ye	ear
rds,	quires the n signe	d by	Part II. Other signif	cant conditions	contributing to de	auri but not res	sulling in the t	indenying t	ause give	m in Part I.			Yes 2			nknown
Division of Vital Records,	sician: The law rec certificate has bee rector, page 2 shou	se Completed	25. Was case referr	red to medical	1					26. Place	of Death	24a. Was auto perfo	psy ormed? 2 No	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings a ompletion of ca 2 □ No	vailable use of
sion of V	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification: To B	examiner? 1 Yes 2 27. Manner of Death 1 Natural 2 Accident 3 Suicide		28a. Date (Mont	of Injury th, Day, Year)	ER/Outpatie 28b. Time o Injury	of M	28c. Injury Work 1 □	4 🗆 Nu	No 2	8d. Describe	how injury			
Divi	tal or Al rs after c al Direc ed in by	Certifi	4 ☐ Homicide	determined	28e. Place	of Injury - At h ng, etc. <i>(Spec</i> i	nome, farm, str ify)	reet, factor	y, office		2	8f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Numb	er,
	n 24 hou n 24 hou se Funer	edical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	miner: On the b	best of my kn asis of examin ner stated.	owledge, deal ation and/or in	th occurred nvestigation	at the tin	ne, date an pinion, dea	nd place, a th occurre	nd due to the	cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	To the	Me	29b. Signature and	title of certifier					c. License		~~			signed (Month		
	,		30 Name and addition	480C		wo-	m 000\ /T -	Delet\	4)	006	317	-6	OCto	ber =	18,20	09
	Sta Registr		30. Name and address 31. Date filed (Mont	enws 1	Nwa	CV112 egistrar's Sign	mere	, M V	3 90	00 FR	ANKL	in Sa	care	DR Ba	lto md a	21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4:45 PM Month Day Year **Physician** 2009 YI LIAN LI 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner square Hos ranklin . Age (In yrs. last birthday) State or Foreign Social Security Number **Funeral** Hours Min. 1092077938 1 □ M 2 🔀 F Months Days CHINA 095-68-7149 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experient must be notified at once. Baltimore City 1 Nes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number China 21224 3526 E. Fairmount Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2X Married Specify: Asian 1 □Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3526 E. Fairmount Avenue, Baltimore, MD 21224 Xuan De Li, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Frost Woods Cemetery 11/03/2009 East Brunswick, NJ 4 ☐ Donation 5 ☐ Dther (Specify) 22. Name and Address of Facility Wah Wing Sang Funeral Corp. T. Harman Service Licensee 26 Mulberry Street, New York, NY 10013 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Hmyotrophic

Due to for as a consequence of): Physician /Medical Examiner ratory Muscle Failure de to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: he law requires that the death certificate be executed after death. attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

Baltimore, Maryland 21215-0036

Medical

4 Homicide

29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

, MD

29c. License number

RESOOOC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

10/26/2009

30. Name and odress of period who completed cause of death (Item 23a) (Type, Print) Square Drive, Baltimore, Maryland 21237 9000 Franklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene James Lewis 34837 2009 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 24, 2009 1250 hrs Medical Examiner Robert James Lewis 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 607 Bartlett Avenue **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours Director 223-40-7701 1 XM 2 F Country) 79 Yrs 12-8-1929 VA Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1X Yes 2 No MD 28a-f show N/A Baltimore death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 607 Bartlett Avenue 21218 S Α Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Y Never Married 2 Married Yes Black permit. Pages I and 2 should be filed within 72 hours after i Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", o injury or other traumatic event, the Modrical Examiner. f Yes, Give Year 1 Yes 2 No specify: Specify Widowed Divorced \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Disabled 8th grade Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Rice Frank E. Lewis
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Lewis-brother 2631 Guilford Avenue 21218 Balto, Md 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation -4 - 094 Donation 5 Other Specify: Garrison Forest Owinas Mills, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H Balto, 21202 1101 E. North Avenue Md _ QA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical X AMENDED #1 X UNPENDED attending physician for use as the burial -,23a,27,permE, g897 11/17/09 TT Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. P.O. \$ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available. prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate o the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes ို After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 24 hours after death. the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours at To the Funeral D determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific O.C.M.E. October 25, 2009 cek 30. Name and address of person who completed cause of death (Item 23a)

State

Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month, Da 2009

COME

111 Penn Street, Baltimore, MD 21201

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34838 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ctobe 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death If Under 24 Hrs. Security 7. Age (In yrs last birthday) 8. Date of Birth **Funeral** 9 Birthplace (State or Foreign / Country) 1 □ M 2 🕽 F Months Days Hours Min. North Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show r than "natural", or items 23a or 28a-f shov Director 1 Yes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #105 Funeral 1) Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baftimore, Maryland 21215-0036 1 ☐ Yes 2 1 No <u>چ</u> If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health, and Mental Hygienn Important: If Item 27 is marked other that any InJury or other traumatic event, the answer in Jury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Viar Tha 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Toseph L. Russ 21. Signature of Funeral Service Ligensee Joseph Funeral Home, P.A. Ave. Balto. Md! 212 W. North 23a. Part 1. Inter the disease, or complications that cause the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock if heart failure. List only one cause or each line. Approximate Interval Between One and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Day Year 5 ☐ Other (specify) 9 Unknown page 2 should be detach gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use o tribute to the cause of death? Records, ģ Completed 1 ☐ Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate I Division of Vital 1 □Yes 2 No 1 □ Yes 2/ No Physician: funeral director, 25. Was case referre examiner? medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 Other (Spe 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifie

29d. Date signed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** October 25, 2009 11:25 P.M Lillian Alleen Leonard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 105 Sunshine Court Unit D Forest Hill Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth
 (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕅 F Director 23, 1930 Maryland 212-28-3389 79 Usual Residence of Decedent 10d. Inside City Limits the Marylan 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Experimentment by notified at 1 ☐ Yes 2X No Director Harford Forest Hill Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 United States 105 Sunshine Court Unit D Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23 ury or other traumatic event, it. We filed the required reventy. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 DNio If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White þ 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Artist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estelle Mabel Suit Adam Elwood Martak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Leonard / Husband 105 Sunshine Court Unit D Forest Hill, MD 21050 20c. Location - City or Town, State 20h. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donatjon 5 ☐ Other (Specify) Evanster Funetral otcharel Oct. 27, 2009 Forest Hill, Maryland 21. Signatur of Funeral/Service Licensee Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. Immediate Cause (Final **Physician** MRONIC OVER 10 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours af e Funeral D letely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 ho To the Fune completely f and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and to

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Jason Birnbalm, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

602 s. Atwood Street Bel Air, Maryland

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** 2009 JOHN PAUL LEARD 2:20 **OCTOBER** A /Medical 4a. Facility Name (If not institution, give street and number) 4c., County of Death 4b. City, Town, or Location of Death Examiner 626 A Harborside Drive Joppa If Under 1 \ Harford 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day) **Funeral** Months Days Hours Min. **™** M 2□ F Director 220-07-5856 88 Sep. 7, 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Woolch Era if it at items to item in the continuation. 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location 1 ☐ Yes 2X No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 626 A Harborside Drive 21085 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Calibrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ George Russell Leard Alice V. Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Heilman / Daughter 310 Barksdale Road, Joppa, Maryland, 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 10/30/09 Baltimore, Maryland Servic in n 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sigg 1. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner oncu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sures Examiner Due to (or as a consequence of) ees Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death Month Year 5 ☐ Other (specify) 1 Yes 2 No the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 TYes 2 🗆 No M 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending n 24 hours atter ucce...he Funeral Director: Af investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signatene and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 man 1 20 31. Date filed (Month, Day, 32. Registrar's Sign State Registrar

		For State of Maryla 1 - State Registrar		artment of F <i>rtificate of I</i>		/lental Hyg R	iene eg. No 200	9 34841
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th Day Yea	3. Time of Death
/Medi Exami	cal	LEROY LEVENSON 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	October	27 20 4c. County of D	eath
- K		Sinci Hospital of Baltimo 5. Social Security Number 6. Sex 7. Age (In yr		Bal- If Under 1 Year	timore If Under 24 Hrs.	0 Date of Birth	N/A	Birthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr 217 − 16 − 6211 8!	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, 04/22/1	924	Country) MD
/land		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
ne Mary 18a-fsh	ector	MD BALTIMORE	BALTI					1 ☐ Yes 2X No
h with th	al Dir	10e. Street and Number 6804 MAURLEEN ROAD		10f. Zip Code	209	1	og. Citizen of What USA	Country?
I e, INIAI y IAILIU Z IZIO-0050 S 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Morried if Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE
n 72 ho "natur edical	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of work	ring	16b. Kind of Busine	•
cic d withii ygiene. er than t, the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		LF EMPLOY	ED		RETA	IL
cal ylallu 2 12 2 should be filed with and Mental Hygiene. Is marked other than aumatic event, Ihan	To Be	17. Father's Name (First, Middle, Last) MEYER LEVENSON			18. Mother's Nam ANNA	e (First, Middle, I	Maiden Surname) MOLITZ	
and 2 short and 2 short and 1 m 27 is manner trauma		19a. Informant's Name/Relationship (Type. Print) KARLEEN LEVENSON / WIFE		ng Address (Street		ral Route Number	r, City or Town, Stat , MD 212	· • · · ·
Pages 1 a ent of He nt; if litem		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispo cemetery, cred SHE EMU	psition (Name of matory or other place NAH AITZ C	i i		20c. Location - City	•
parmit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility SO	_ LEVINS	BALTIMORE ON & BROS KESVILLE,	., INC.
*		23a. Part1. Enter the disease, or complications in at caused the de shock, or heart failure. List only one curve on each line.						Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	on bu	eumonitis				Onset and Death
Examiner		Due to (or as a conse						
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fficate be executed physician and streets the burial-transit	edical	d						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□ Ectopic pregnanc □ Other <i>(sp</i> ec <i>ify)</i> _	у		23d. Date of Month	delivery Day Year
S, T. Is that the syned by e detac	by Phy	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.			e to the cause of death?
requires t		Esophageal Cancer				-		Frobably 4 ☐ Unknown
The law ate has by page 2 s	Completed	Atrial Fibrillation		<u> </u>		24a. Was a autops perfori 1 □ Yes	sy prior med?/ death	
siclan: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Propagation 2		Oth	26. Place of Dear	th (Check only on	ne)	
ng Phy fter this	on: To	27. Manner of Death 1	28b. Time o	nt 3 DOA	4 LI Nursing H		ence 6 Other (5 ow injury occurred	Specify)
uttendil death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At		M 1 🗆	Yes 2□No	28f Location (S	treet and Number of	Rural Route Number,
Ital or / Ital or / Ital or / Ital or / Ital or / Ital or /	Certi	4 Homicide determined building, etc. (Spe	cify)			City or Town	n, State)	
he Hosp in 24 hou he Funei pletely fil	Medical	29a. Certifier (Check only one) 1						
vithi To th	Z	29b. Signature and title of certifier MBBS		29c. Licens	e number	2	29d. Date signed (M	1
61		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print)			10/27	1 1
	oto.	Dr. SUMIT KAPOOL SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature		ALTIMORE			
Sta Regist		OCT 30 2009 Serve S.	park	<i>y</i>				

PH known as Leroy, Levenson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g896, 10/29/199dib Certificate of Death Reg. No. 2 Reg. No. 2009 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 3:00 P.M **Physician** Loretta Ann Leuschner 2009 October 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 3813 Brooklyn Avenue 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 07/13/1953 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min 1□M 2∰F Mary Land 56 Yrs. 215 62 0062 Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It woodcal Exa, incomust be notified at 1 Yes 2 □ No N/A Baltimore Director Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 3813 Brooklyn Avenue Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify ρ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vehicle Transportor Amport Auto 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvester Oliver Carolyn McNair 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 3813 Brooklyn Avenue Paula Vogel Neuber / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/2009 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Puneral Service Li 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year-Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27 Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3001

KNOUER St. Ba

and manner stated.

#2 Hd, 100

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** WAYNE LUIZ рМ R. October 0 2009 4:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 125 Circle Road Pasadena Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Maryland Director 1933 213-30-2321 Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Maryland Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 125 Circle Road 21122 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Xes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□Yes 2□XNo Maryland 21215-0036 If Yes, Give Year or Dates Specify Specify: ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be flied within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "rayn jury or other traumatic event, It a Mexique. Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Adjuster Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dona1d Dandy 2 Milton Lutz, Sr. Gertrude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 125 Circle Road Pasadena, Maryland 21122 Fave Lutz (Wife) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 10/31,2009 | Brooklyn Park Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagh line. Immediate Cause (Final disease or condition resulting in death) ars **Physician** 101 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed' certificate 1 ☐ Yes 2 ☑ No Division of Vital the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the i 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature/a e of certifie DUU58779 202 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lan Burnse 2106 30 L 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Janice Golonika Leake

2009 34844

			egistrar		Certificat	e or	Deatti					eg. No.		T2
Phy ledical Ex	/sicia kamir	n/ ier	Decedent's Name (First, Middle,L Janice	Golonka I	Leake						Date of Dea Month October 2	Day 23, 2009	Year	3. Time of Death 2020 hrs
		4	la. Facility Name (if not institution,			41	b. City, Town, Baltimore		cation of	Death		4c. Cou	inty of Dea	ith
F. Acr			529 North Charles Stree 5. Social Security Number 6.		yrs. last birtho	lav)	If Under 1 Y		If Under	24Hrs. 8	3. Date of Bi	rth (MM/DD/)	(YYY) 9. E	Birthplace (State or
Fun Dire			553-76-9090		1 4			ays	Hours	1.00	12/29		Fore	eign Country) CA
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-	any	-	10a. State 10b. County	100	City, Town or	Location								10d. Inside City Limits
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the N	23a or 28a-f sho notified at once,		529 North C	harles Stree			212						SA	
h with	be n	Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was	Decedent of es, specify Cut	Hispa ban, N	nic Origir Nexican, F	n? (Spec Puerto Ric	ify Yes or N can, etc.)		Race - Am White, etc.	erican Indian, Black,
ır deat	or it	튄		1 Yes 2 X	No	1	Yes 2X	No.	enecify:			Sne	cify: W	<i>N</i> hite
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21215-0036 wild be filed within 72 hours after death with the Maryland Mental Hygeine.	arkec event,	Be	Thomas Jose 19a. Informant's Name/Relationship		19h	Mailing	Address (S				Mar			ate, Zip Code)
and sho	7 is	٤	Florence Golonk		151	12 W	. Ocea	nfr	ont,	New	port :	Beach,	CA 9	2663
	traur	-	20a. Method of Disposition		20b. Place of			ceme	etery,	I	Date	20c. Loca	ation - City	or Town, State
10r ages 1 nt of 1	other If		1 Burial 2 X Cremation		Final 3	Jour	ner place) ney Cr	em.	, þ	0/30	/2009	Woo	dbine	e, MD
Baltimore, permit. Pages 1 ar Department of Hea	Important: injury or oth	ŀ	4 Donation 5 Other Special Service Li		rshall	22. N	lame and Add	ress o	f Facility	-ema	tion	Serv	ices	
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Physi			23a. Part I. Enter the disease, or confailure. List only one cause of		death. Do not	enter th	ne mode of dy	ing, sı	uch as ca	ardiac or r	espiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and
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Box e death c	d for u	Physicia	1 Yes 2 No 9 V Unkn		3		(Opcomy)							
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Division of Vital Records, P.O. all or Attending Physician: The law requires that the control of	After funera		27. Manner of Death 1 Natural 5 Pendii	28a. Date of Injury (Month, Day,Year	r)		1		es 2 X		unk	, o , , o , , , , , , , , , , , , , , ,		
Sio Atten	ector: by the	cati	2 Accident Invest	igation FG 10/23/	/ 09 Fd. -v - At home, fa	/ : 50 rm, stre	U pm off	ice bu	ilding, et	tc.	28f. Location	n (Street and	Number o	r Rural Route Number, City Charles St
Div	al Dir	Certification:	3 Suicide 6 X Could 4 Homicide	not be							Apt Town	ol Bal	timor	ce, MD
Hospi	Funer Funer tely fil		29a. Certifier 1 Certifying Phy	sician: To the best of my k	nowledge, dea	ath occu	rred at the tim	e, dat	te and pla	ace, and o	due to the ca	ause(s) and i	manner as	stated.
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer	willing 24 fours and used. To the Funeral Director: After t completely filled in by the funeral	Medical	one) 2 Medical Exam	niner:On the basis of examinand manner stated.	nation and/or i	nvestiga				curred at	the time, da			
-		ž	29b. Signature and title of certifier						number				ite signed per 24, 2	(Month, Day, Year)
			Hanaly Vu	thall MD				.C.N	/I.⊏.			OCIO	JGI 24, Z	
1			30. Name and address of person v Pamela E. Southall, M			r 11	11 Penn St	reet	. Baltim	nore. M	D 21201			
		toto			Signature	_		551	,					
		tate trar	31. Date filed (Month, Day Year)	009	A	Sal	Kal							

State of Maryland / Department of Health and Mental Hygiene 2009 34845 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mullin October 22, 2009 9:14 PM Stanley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 331 Harwick Place Joppa If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday 8. Date of Birtl **Funeral** Min. 1 X M 2 ... F Months Hours 0370971954 Massachussettes **Director** 019-44-5629 55 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location the Maryland notified at Director Harford 1 Yes 2 X No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò event, the Medical Examiner must be Funeral 23a 331 Harwick Place 21085 United States permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married ^{2 □ No} Era Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates. Vietnam Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Metallurgist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ James Wilfred Mullin Pauline Steele McIsaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Steele, Mother 120 Dartmouth Drive, Bristol, TN 37620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State Akard Funeral Home 10/28/2009 4 Donation 5 Other (Specify) Bristol, TN Harman Funeral Service, PA 21. Signature of Funer Service Licensee 22. Name and Address of Facility 7221 Grayburn Drive, Glen Burnie, MD 21061 T.Harman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the built own plotted filled in by the funeral director, page 2 should be detached for use as the built. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify ၉ 1 Inpatient 2 I ER/Outpatient 3 DO/ 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Matural 1 🗆 Yes 2 🗆 No Accident investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical txaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License number october 26th 2009 6444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602. ATWOOD Road. Belair. MD21014 UIJAY, S. NAIR. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 34846 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 23, 2009 John Louis Mann Sr. 6:10 РΜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Little Sisters of the Poor Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 7-27-1917 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 578-10-7391 92 Director Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 23a or 28a-f show ust be notified at 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (Ayes 2 □ No 1943– If Yes, Give Year or Dates: 1945 r than "natural", or items the Medical Exeminar 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 2 Specify white 3 X Widowed 4 ☐ Divorced 1945 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ampiniury or other traumatic event, I ame and other. Elementary/Secondary (0-12) College (1-4or 5+) Business Manager Plumbers Union Plumbers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank A Mann Nora Toomey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Mann, Jr. <u>7614 Fairfax Road, Bethesda MD 20814</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery Oct. 30,2009 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign rure A Moneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MEMI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Dinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death

To the Funeral Director: / 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number dikarar October 27, 2009 21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAMBANDAM BASKARAN 3455 Wilkens Are Baltmare, MD 21229 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month A 12:05PM CINTYRE 2009 10 /Medical 26 42. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner venwood If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** 1**№**M 2□ F 411-36-3228 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Director mI 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 501 W. Franklin 21201 by Funeral filed within 72 hours after death Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner mu
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To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 HO ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 -Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar

SAN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Kumar 32. Registrar's Signature

asanthalun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

State of Maryland / Department of Health and Mental Hygiene a a a

			For State Registrar	Otato or wit	arylana /	Cer	tificate	of L	Death	violitai 11	Reg. N		9	34848
20	14 1 18		Decedent's Name (First, Middle, Last	st)						2. Date of D Month	eath	ay Yea	ar I	3. Time of Death
200	Physicia /Medic		MARY		MAR	RON)			OCTORE	-	8 200	٩	19:55 PM
	Examin		4a. Facility Name (If not institution, give	e street and number)					Location of Death	1	4	c. County of D		
	A second		7604 Meadow Way	17.4	. (1	1:4-1-1	If Under 1		dalk If Under 24 Hrs.	10 D-t(D		Balti		
E	Funeral Director		5. Social Security Number 6. S 186–12–0625 1 Usual Residence of Decedent	ex 7. Ag □M 2 X IF	e (In yrs. last 89	Yrs.		Days	Hours Min.	8. Date of B (Month, D October	lav, Yea	r)	Countr	ce (State or Foreign y) and
	land ow tt		10a. State 10b. County		10c. City, To	own or Lo	cation						100	d. Inside City Limits
	Mary a-f sh ffied a	tor	Maryland Baltimo	ore		Du	undalk	2						1 ☐ Yes 2 ☐XNo
	th the or 28g	irec	10e. Street and Number				10f. Zip (Code			10g. C	Citizen of What	Countr	y?
	tth wii 23a c ust b	ral	7604 Meadow Way						21222			USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Vas Decede f Yes, speci I □ Yes 2		spanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	lo-	14. Race - A Black, W Specify:		c.
9	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	lucation	10	6a. Deced	lent's Usual	l Occup	ation	kina	16b.	Kind of Busine	ss/Indu	istry
215	ithin 7 ne. nan "r Med	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)				during most of wor)	Kilig	1			
	filed withii Hygiene. other than ent, the M		12 years			Don	nestic	En	gineer	- /5: 4 42-1-1		Own Ho	me	
Maryland	be fil ntal H ed oth even	Be	17. Father's Name (<i>First, Middle, Last)</i> Denis Harkin						18. Mother's Nan Annie H		е, маіде	en Surname)		
ž	should be tand Mental Is marked or umatic eve	ပ	19a. Informant's Name/Relationship (Time Print)	1	Oh Mailin	a Addraes	(Street	and Number or Ru		her Cih	v or Town Stat	a Zin (Code)
Ma	id 2 sho Ith and 27 is me traume		Kathleen T. Marro						Creamery		-			-
	s 1 and 2 f Health tem 27 other tr		20a. Method of Disposition				sition (Nam natory or ot		· ·	Date		Location - City		
9	Pages ent of nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1		<i>l</i> alley		,2,0,0	mber 2009	Tin	monium,	Mai	rvland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong once.		21. Signature of Funeral Service Licer	<u></u>	000		. Name and	Addres	ss of Facility uneral H rs Point	ome of	Dund	dalk.P.	Α.	-
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death	, 						Jain, III		Approximate
	Physician		Immediate Cause (Final											Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequent	ce of):								
	Examiner		Constant the first one state on	b										
- 9	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ce of):								
	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									1	
60,	be ex cian a	E E	Tooling III oodiii, Edo	Due to (or as	a consequent	ce on:								
68760,	icate physi s the b	Medical		_d									+	
. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 mothths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3 □	Ectopic pre Other (spe		1			23d. Date of Month		y Day Year
, P.O	that led by deta	/ Ph	Part II. Other significant conditions of	ontributing to death b	ut not resultin	g in the ur	nderlying ca	use giv	en in Part I.	23e. Dio	tobacce	o use contribut	e to the	cause of death?
Records,	quires n sigr ıld be	d by	HYPERTENSION							1 🗆] Yes	2 / No 3 □] Proba	bly 4 □Unknown
000	s beer shou	Completed								24a. Wa		24b. Were	autop	sy findings available
Re	The lav te has age 2 :	omp								aut per 1⊟ Yes	opsy formed?	deati	٦?	pletion of cause of 2 □ No
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical						26. Place of Dea			101		
<u>r</u> <	Physician: this certific ral director,	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 □ ER/	Outpatien	t 3 DO	A Oth	er: 4 ☐ Nursing H	lome 5 D∕Re	sidence	6 Other (5	Specify)	
n or	ding Physician: The n. After this certificate his funeral director, page	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		b. Time of Injury	28	8c. Injur Worl	y at k?	28d. Describe	e how in	jury occurred		
Sio	Attending r death. ector: After by the fune	catio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	les established			М		Yes 2 □ No					
Division	• Hospital or Attend 24 hours after death • Funeral Director: etely filled in by the f	Certification:	4 Homicide determined	28e. Place of inj building, et	ury - At home c. (Specify)	, farm, str	eet, factory,	, office		28f. Location City or T	(Street own, Sta	and Number of ate)	r Rural	Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical (29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of examination	dge, death and/or in	occurred avestigation,	at the tir in my o	me, date and place pinion, death occi	e, and due to thurred at the time	e cause e, date a	e(s) and manne and place, and	r as sta due to	ited. the cause(s)
	To the within To the Comple	ME	29b. Signature and title of certifier	,			29c.	. Licens	e number		29d. [Date signed (M	onth, D	Pay, Year)
			James Ha	noh	MD		7	56	2032		00	T 29		2009
	11		30. Name and address of person who	completed cause of d	leath (Item 23	a) (Type,								
	1 '		JENNIFER HAYAS		HOPK	INS	BAYV	IEW	CIRCLE	BAL	CIMC	ORE, MD	21	224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	bak	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician October Anna Elisabeth McCleary 7:40 Ам 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Stella Maris Nursing Home Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ м 2🛣 F Months Hours Min Days 84 219-34-0095 **Director** Germany June 20, 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b County 10c City Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be neithed at 10d. Inside City Limits MD Baltimore Director Baltimore 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8517 Fowler Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces
1 ∐Yes 2 XI
If Yes, Give
Year or Dates: 1 Never Married 2 Married 7:40 A.M. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 5 Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Karl Schenke Martha Barde 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important; If item 27 is any injury or other trainonce. Annamaria Walsh/ Daughter 1837 Deveron Road, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Lakeview Memorial 10/30/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility
Evans Funeral Chapel & Cremation
8800 Harford Road, Parkville, MD 21. Signature of Funeral Service Licensee 2.7a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 5 ock, or heart failure. List only one cause on each line. Approximate Interval Between diate Cause (Final Onset and Death **Physician** ongesti Neek resulting in death) /Medical Due to (or as a con guence of) Examiner Sequentially list conditions Examiner Due to (or se a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? detached for 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.O. 9 Unknown has been signed by e 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2♠ No 24a. Was an autopsy performed? **Division of Vital** 1 □Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2√ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 □Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINR WRIGHT, M.D.2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2009

OCTOBER

ANNA MCCLEARI

7	Mental Hygiene 2009	34850
n and	Mental Hygiene	

			1 - For State Registrar	Otato of Mic	ii yidiid / D	Certificate of L	Death	nontal riy	Reg. No.	2009	34850
	Physicia		1. Decedent's Name (First, Middle, I					2. Date of Dea	ath		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, g Saint Josep	ive street and number)	Center	4b. City, Town, o	r Location of Death			ounty of Death	timore
	Funeral Director				(In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h /, Year)	9. Birth	place (State or Foreign htry) Panama
			Usual Residence of Decedent				1	November	22, 19		
	aryland a-f sho fied at	Director	10a. State 10b. County Florida Saraso	ota	10c. City, Town					,	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M. a or 28 be noti		10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?
	ith with	Funeral	260 Santa Maria 11. Marital Status	Street, Un		34285	ispania Origin? (Sp	oify Vos or No	_	.S.A.	1.00
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖔 No		Rican, etc.)		Black, White,	
15-(72 hou	Completed	15. Decedent' (Specify only highest	grade completed)		Decedent's Usual Occup Give kind of work done of ife. DO NOT use retired)		ing	16b. Kind	of Business In	dustry
212	d withir ygiene her tha nt, the	Be Co	Elementary/Seconday (0-12)	College (1-4 or 5- 4		nemical Eng				mical	
Maryland	d be filed Mental H arked ot atic ever	To B	17. Father's Name <i>(First, Middle, Las</i> John Marks Moor				18. Mother's Nam Bernice	e (First, Middle, Cobb	Maiden Su	rname)	
, Mar	id 2 shoules alth and n 27 is mer traums		19a. Informant's Name/Relationship John Marks Moore			Mailing Address (Street)					= '
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	cemetery	Disposition (Name of crematory or other place C	ce) i	Date 29/2009		ation - City or To	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic	ensee Ludi)	22. Name and Addre	ss of Facility Ruck Road, T				me, Inc. 204
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that caused y one cause on each line.	the death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	RATORY consequence of	FAILURE				-	Onset and Death
Service Service	Examiner	ř	Sequentially list conditions,	b. —	S SYND						
	rted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		consequence of	: PNEUMONIA					
0	ificate be executed ig physician and as the burial-transit	cal Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760		Medical	IF FEMALE:	_ d.							
Box 6	The law requires that the death cert atte has been signed by the attendir page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death	3	су		23	d. Date of deliv Month	ery Day Year
s, P.O.	res that the signed by	by	Part II. Other significant conditions URINARY TRA	contributing to death but	•	the underlying cause given	ven in Part I.	23e. Did to			ne cause of death?
of Vital Records,	w requires the sbeen signers should be o	Completed	SEVERE DEME	NTIA				24a. Was a	an i	24b. Were auto	psy findings available mpletion of cause of
Rec	: The law cate has							autop perfo 1 🏻 Yes	rmed?	death?	
/ital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	at 2 D FR/Out	26. Pl	ace of Death (Chec er: 4 Nursing Ho		lanca 6	Other (Specific	d
of/	ding Phy h. After this funeral d		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	/ 28b. Ti		y at	28d. Describe h			9
Division	l or Attending after death. Director: After I in by the fune	Certificate:	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no	t be 280 Place of Injur	v - At home, farr	M 1 🗆	Yes 2 □ No	28f. Location (S	treet and N	Jumber or Rural	Route Number
	Hospital or 1 24 hours after Funeral Dire			building, etc.				City or Tow	n, State)	_	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N	hysician: To the best of n miner: On the basis of ex- urse Practioner: To the b	amination and/or	investigation, in my opinio	on, death occurred a	t the time, date a	nd place, ar	nd due to the ca	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of contifier	teloy M	.4.	29c. License	7695		29d. Date s	igned (Month,	27, 2009
	41/		30. Name and address of person wh	o completed cause of de	and do be		RIUE TO	JWSON, I	MORVI	AND S	1204
	Sta		ABDALLAH J F 31. Date filed (Month, Day, Year)	32. 30 strar			rid V lin E	orvenitoring i	/1 /2 \ 1 L	mari di Taluf - Tana	we don't be "
Dist	Registra	ar	OCT 3 0 2	UU9 Brown	1.0	bast !					

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 27, **Physician** SPENCER MAXWELL 2009 8:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 4669 COLUMBIA RD ELLICOTT CITY HOWARD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 13, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ₩ 2 □ F 220-44-5294 84 ENGLAND Director Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4669 COLUMBIA RD 21042 IISA r death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 127 is marked other than "n traumatic event Elementary/Secondary (0-12) College (1-4or 5+) MINISTER CHURCH permit. Pages 1 and 2 should be file Department of Health and Mental H Important; If flem 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARTHUR STANLEY MAXWELL RACHEL ELIZABETH JOYCE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HEIDI TIMBERLAKE-DAUGHTER ELLICOTT CITY, MD 21042 4669 COLUMBIA RD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/29/09 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY GLEN BURNIE, MD 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 21. Signature of Funeral Service Licensee 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Rart . Enter the his shock, or heart failu ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ment /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after dea. 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numb 30. Name and address of person \ to opmpleted cause of death (Item 23a) (Type, Print) 71 81) 32. Registra/s Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - State Registrar 34852 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SHIRLEE MCCARTHY OCTOBER 24,2009 20:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death CALVERT MANOR RISING SUN CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F Director 186-14-7181 88 NOV. 12,1920 PA Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 □Yes 2 □ No Director MD CECIL RISING SUN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1881 TELEGRAPH RD 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: WHITE þ Specify: 3 Widowed 4 □ Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 BILLING DEPARTMENT BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental HARRY A. RUSSELL MARY JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY HAMILTON-DAUGHTER 58 LEEDLE CIRCLE Health a RISING SUN, MD 21911 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 10/29/09 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral a rvice Licensee 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part1. Enter the dis e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate C e (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death Month Dav Year 5 Other (specify) signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No autopsy perform certificate 2 200 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending 2 Accident investigation 1 Yes 2 No 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dimana 31. Date filed (Month, Day OCT 3 0 Day, 32. Registrar State Registrar

DHMH 17 Rev 1/2001

Baltimore,

Division or Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death october Mebert Helen **Physician** 0150 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard **Howard County General Hospital** Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗙 F Months Days Hours Min Director NY 90 132-03-3108 Nov 20, 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, Ite Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10799 Hickory Ridge Rd. Apt.# 320 21044 U.S.A Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Wo Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donat Blazewicz ٩ Julia Bobcyk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Volk daughter 11902 New Country Lane Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Columbia Memorial Park Oct 28, 2009 Clarksville, Maryland ure of Funeral Service Lio 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physiciar by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy be detached for Month Year Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown led by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Dehydration 2 No 3 Probably 4 Unknown Completed malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy atherostlerotic coronary disease certificate 1 □Yes 2/ Nio 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√20No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier D0053312 October 25, 2009 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print) cedar Lane, Columbia, MD A. Hengseler 5755 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Katie Mae Oland 12:20 P /Medical Oct 28, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Woodstock Howard 1509 Grooms Lane 5. Social Security Number Age (In yrs. last birthday, If Under 1 Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Min Months 1□M 2×5 Hours Director MD Mar 6, 1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1509 Grooms Lane 21163 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 210 No Baltimore, Maryland 21215-0036 1 Tyes Specify ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Vernon Samuel Bloom Gertie Mae Woodward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once. Calvin W. Oland, Sr. Husband 1509 Grooms Lane Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 Removal from State Poplar Springs, MD Poplar Springs Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy performe 2 **A**No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 5 Residence 6 □Other (Specify) After this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

of death (item 23a

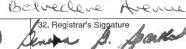
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State Registrar 2434

31. Date filed (Month, Day, Year) OCT 3 0 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A i N A

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	a or 2	٦	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	untry?
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Baltimore, Maryland 21215-0036	permit. F Departm Importal any injul		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility		wood.	Lawii,	nu
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3876	rtificat ing ph e as th	/Mec	IF FEMALE:							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M		2 Fetal death 3	Country (Specify)	су		23d.	Date of deli Month	very Day Year
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Division of Vital Records, P.O.	rsician: The law red s certificate has be lirector, page 2 sho	Completed					24a. Was autor perfo 1 □ Yes		prior to c death?	opsy findings available ompletion of cause of
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	りく		30. Name and address of person who completed cause of o	death (Item 23a) (Type, F	Print) THE ALAN	neba B	SITIMOR	e mo	21	218
H	Sta Registr		31. Date filed (Month, Day, Year) 0CT 3 0 2009	rar's Signature	del .					

Patient Known as Pierson, Ellen

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with th	d or 20		10e. Street and Number 2920 Windsor Ave				10f. Zip Code	1216		10g. Citizen of Wh		y?
5-0036 72 hours after death with the Maryland	Inan Haura, or nems 23a of 20a-1 snow	by Funeral		2. Was Decedent Armed Forces? 1Yes 2! If Yes, Give				Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No Rican, etc.)	U • S 14. Race Black Specify:	- America , White, etc	c.
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Baltimore, Maryland 21215-0036 Permit. Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiens.	iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		sition (Name of natory or other place	onal]1/	ate	20c. Location - C	-	
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Physi /Med	cian dical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pleu	ral ef	fusio		ng, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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Division of Vital Records, all or Attending Physician: The law requires the after death.	completely filled in by the funeral director, page	Certification: To										
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To the Hospital of within 24 hours at To the Funeral D	nin 24 hour the Funera	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									ited. .he cause(s)
P ∰ P	cor	Σ	29b. Signature and title of certifier		RES (29d. Date signed (Month, Day, Year)						
4	, V	- 1	30. Name and address of person who con				Print)	W. Belvedere	Allo	Rultimore	MD 21	1215
	Stat	е	31. Date filed Arapth Day, Yes 2009	32. Registra	ar's Signature	Aran	i	PCINCIALL	- FIVE)	PACE LISTENCE		
DHMH 17 F	egistra		A A 1 A 2000	Value of the same	Po. 40	TETES TO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34858 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and nun **Examiner** 4b. City, Town, or Location of Death unty of Death n yrs. last birthday) 83 Yrs. . Age If Under 24 Hrs. 8. Date of Birth If Under 1 Year **Funeral** 9. Birthplace (State or Foreign Min Day, **Director** Usual Residence of Decedent oortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Ktor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 11.5.1 120 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
I Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M once. econday (0-12) Be 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place arkuille, mo 21. Signature of Funeral Service Licenses chapel-Monkton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury) Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ☐ Yes 2 L ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform this certificate Yes Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify 28a. Date of injury (Month, Day, Year) 27 Manner of Death Natural 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 5 Pending Accident 2 | No Investigation within 24 hours are:

To the Funeral Director 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title License number 29d. Date signed (Month, Day, Year, 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

			1 - For State Registrar	State of Marylar	id / Depa <i>Cei</i>	artme rtifica	nt of H te of L	ealth and Death		gien e Reg. No.	009	34859	
Ī	Physici /Medic		1. Decedent's Name (First, Middle, Last, John Evelin	Paige	2. Date of D Month Octobe				Day Year				
i .	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of Deat	h		County of Death	1	
			Pineview Nursing &	Rehab			nton				ince Geo		
B	Funeral Director		229-22-1894	7. Age (In yrs. 83	last birthday) Yrs.	If Und Months	er 1 Year s Days	If Under 24 Hrs Hours Min.		th 192 y, year, er 13	9. Birthr Coul Richt	place (State or Foreign nond, VA	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					[-	0d. Inside City Limits	
5-0036 72 hours after deeth with the Maryland	Maryli	o	Maryland Prince Ge									1√2Yes 2 No	
	28a-	Directo	10e. Street and Number	orge s le	nple H:		ip Code			10g. Citiz	zen of What Cour	ntry?	
	3a oi		3906 Buck Creek Ro	ad			2074	0		***	. 1 0	•	
	deeti	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Dec			Specify Yes or No to Rican, etc.)	יבחט.	ted Stat	an Indian,	
350 irs after	72 hours after deeth with the Marylan natural', or Items 23a or 28a-f ehow citeal Examinat mara be netified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1		2€No	Specify:	to ricall, etc.)		Black, White, Specify: B1	^{etc.} ack	
215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	dent's Us	sual Occupa	ation	rkina	16b. Kir	nd of Business/In	dustry	
7	within ene. then	npie	Elementary/Secondary (0-12)		(Give kind of work done during most of working life. DO NOT use retired)								
7	00		Twe1th	None	Mec	hani	c	40. 14-15-1-1-1	- 15' - 15'-11		vate		
Maryland	S = 5	Be	17. Father's Name (First, Middle, Last) Phillip Paige					Emma A	me <i>(First, Middl</i> e, 11op	малоеп.	Sumame)		
Ë	should nd Men marke umatic	건	19a. Informant's Name/Relationship (Ty	rne Print)	19h Mailin	na Addre	es /Street s		ural Route Numb	ar City or	Town State Zir	Code	
<u>8</u>	and 2 sealth an n 27 is		Helen Jackson/Nied						Temple H				
9	O T T T		20a. Method of Disposition t☐Burial 2 ☐ Cremation 3 ☑ F	IGINOVALI II OIII OLALO	Place of Dispo			J				own State Mile Rd	
	permit. Page Department of Important: If any injury or 2005.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		wood C		_	2009			mond VA	al Home Inc	
ğ	Dep impo		> MR.G2	\checkmark	16	61 G	ood E	lope Rd	SE Washi	ngto			
			23a. Part1. Boter the disease, or compl shock, or heart failure. List only or	ations that caused the deat e gause on each line.	h. Do not ent	er the m	ode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
′ /M	Physician		Immediate Cause (Final disease or condition resulting in death)	Dementia								Onsol and Death	
	/Medical Examiner			Due to (or as a conseq									
		-	Sequentially list conditions,	Parkinson's	Diseas	e							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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09/89	ficate be executed physicien and s the burial-transit	edicai		d									
	ng ph	Med	IE EEMALE.										
ŏ	death certifi e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								3d. Date of deliver	ery Day Year	
	the all	/sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)								Total Say Total		
7.	w requires that the de been signed by the should be deteched										se contribute to t	ne cause of death?	
ecords,	uires sign d be	d by	Athemacalametic Camdiayacaulam Disagge								2 ANO 3 Probably 4 Unknown		
Ö	law req as beer 2 shou	Completed	24a. Was an							an	24b. Were autopsy findings available		
Ľ	hysician: The law nis certificete has l I director, page 2 s	m C							autor perfo	rmed?	prior to co death?	psy findings available mpletion of cause of	
VII	an: T tificet tor, pa	0	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only o		1 🗆 Yes	2 <u>X</u> No	
<u> </u>	ysicii is cer direct	O B	examiner?	lospital:	ER/Outpatien	t 3 🗆 🛭	Othe Othe	200	dome 5 ☐ Resi		S ∏Other (Specil	iv)	
SION OT	ding Ph h. After th funeral	n: T	27. Manner of Death 1 Manual 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28d. Describe			,,	
	tendir death. tor: Af the fu	atic	2 Accident investigation	(, 22)	(Month, Day Fear) Injury			M 1 Yes 2 No					
DIVISION	el or Att s after de il Directu	Certification:	3 Suicide 6 Could not be 4 Homicide determined					(Street and Number or Rural Route Number, Town, State)					
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director,	edicai (29a. Certifier 1XCertifying Phy (Check only one) 1 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurre vestigation	d at the tim on, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)	
	To the within To the comple	Me									ite signed (Month, Day, Year)		
			75	D0050	0050545 October 28,2009								
			30. Name and address of person who co	- (0)	n 23a) (Type,	Print)							
			Godswill Okoji MD	7513 New Ham	pshire	Ave	., Ta	koma Par	k MD 209	06			
100	Sta Registr		31. Date filed (Month, Day, Year)	32. Aegistrar's Signa	itues.	arks							

			For State Registrar		State	of Mary	land / Depa <i>Cel</i>	rtment of <i>rtificate o</i> a	Health and I f <i>Death</i>	Mental Hygi Re	iene 2 0 0	9	34860	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death								n	/oar	3. Time of Death	
	Physicia Medic/		ERIC C.	PARTHRE	E, JR.					OCTOBER	23°, 20	09	1:15 A M	
-	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town,	or Location of Death	1	4c. County of Death			
	6004 MANNINGTON AVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)							BALTIMO if Under 1 Yea		8. Date of Birth	NA NA	NA 9. Birthplace (State or Foreign		
	uneral irector		217-46-0		1 X M 2 □ F		64 Yrs.	Months Day		MARCH 21	1945	Cour	MD	
pu	>		Usual Residence o			140	c. City, Town or Lo	antion				1	0d. Inside City Limits	
aryla	shov	ō	10a. State	10b. County			BALTIMOR					'	1 ☐ Yes 2√∑ No	
the N	28a-	Director	10e. Street and Nu				DALITION	10f, Zip Code		10	Og. Citizen of Wh	nat Cour		
h with	3a or		6004 MAN	INTNCTON	AVE			21206		1	JSA			
r deat	ems ;	Funeral	11. Marital Status		12 Was Dec	cedent Ever	in U.S. 13.		f Hispanic Origin? (Suban, Mexican, Puert		14. Race	- Americ		
3-0030 72 hours after death with the Maryland	or it	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes, Give 1 Yes 2 No 1 Yes 2 No 1 Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates:							,	Specify:			
S hour	atural cal Eu			15. Decedent's	s Education		16a. Dece	dent's Usual Occ	upation		16b. Kind of Busi			
	an "	Completed	(Spec	cify only highest	grade completed	(1-4or 5+)	life. I	OO NOT use reti	*	king		D= 4	THE DARRE	
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pe pe	tron meant and weather righters are them 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at	Be c	17. Father's Name ERIC C.							ne <i>(First, Middle, N</i> NE M。 JOI		,		
should	is mark	၉ .	19a. Informant's N	lame/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Stre	et and Number or Ru	ıral Route Number,	. City or Town, S	tate, Zip	Code)	
d 2 4	27 is er trau		ROBIN PO	LEC-FRI	END/PERS	ONAL	REP 451	7 RASP A	VE BALTI	MORE, MD	21206			
	If item		20a. Method of Dis		3 ☐ Removal fron	State 2	20b. Place of Dispo	sition (Name of natory or other p	lace)	I .	20c. Location - C			
rmit. Pages	Department of Heal Important: If item 2 any injury or other once.		4 Donation	5 ☐ Other (Sp	ecify)	T Granto	PARKWOOD		i		BALTIMOR			
permi di	Important in any ir		21. Signature of F	meral ervice L	Icensee		1.			LLER-DIPI LTIMORE,			HOME, INC	
			Approximate										Approximate Interval Between	
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of the second		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
ficate be execu		-	resulting in death) Last Due to (or as a consequence of):											
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b certif		n/Me	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, o			7			23d. Date	of deliv	ery	
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The lar	age 2	Completed								autops perforn 1 🗆 Yes 2	ned de	for to co eath?	ompletion of cause of 2 □ No	
VICAL ician: T	artifica ctor, p	BeC	25. Was case refe	rred to medical					26. Place of Dea	ath (Check only on		_ 103	2010	
Physic	his ce Il direc		examiner? 1 Yes 2 No									fy)		
ding P	After i	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work? 1 Yes 2 No											
VISION Attending	ctor:	fica	3 Suicide 6 Color River Color											
tal or	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.8	Certification: To	4 ☐ Homicide	dotoiiii	buil	ding, etc. (specify)			City or Town	n, State)			
UNISION OF VICE THE COLOS, P.O. BOX Of the Hospital or Attending Physician: The law requires that the death certification of property of the control of the death certification of the		Medical	29a. Certifier (Check only		xaminer: On the	basis of ex	amination and/or in		e time, date and place by opinion, death occ					
o the		Med	29b. Signature inc	d title of perfine	7 and ma	nner stated		29c. Lice	ense number	2	9d. Date signed	(Month,	Day, Year)	
				TUL				DOG	057359		10/261	109		
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teltry S. Wolf, MD 16 Soon Bully St. Suite Soo Bully man, mp											
	Sta	te	31. Date filed (Mor			Registrar's		-	20,14 3	1 20.1		741	(الهزأ المندين	
	Registr		OCT 3	3 0 2009	Denva) A.	Jacks					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amedn #14. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34861 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:42 PM 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death baltomore sultimore 57/Chinst Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Hours Director 509-96-0558 Kansas May 2, 1979 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5007 Southern Star Terr. 21044 or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Fold AMUNICAL Baltimore, Maryland 21215-0036 2 No 1 Tes Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Software Engineer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry Michael Pope Diane Louise Chandler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Pope spouse 5007 Southern Star Terr. Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 31, 2009 Clarksville, Maryland Columbia Memorial Park Signature of Funeral Survive Licensie 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Golumbia Pike Ellicott City, MD 21043 38/1 Old Columbia Pike Ellicott Cr 23a. Part 1.—Enter the tilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) nenth Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗆 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Hospital or Attending Physician; The law requires t 24 hours after death. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 🗘 No 4 Nursing Home 5 Residence 6 other (Specify, ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natalle E We St MO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **2** Certificate of Death 2. Date of Death Day Year Month **Physician** 1839 PM 2009 October /Medical 4b. City, Town, or Location of Death 4c. County of Dear 4a. Facility Name (# not institution, give street and number) **Examiner** Hospita N Baltimore Baltimole If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, HUIG, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∠**M 2□ F ano Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It at the clean than the traumatic and the statement of the statemen 1 Yes 2 No Director 10f. Zip Code 10e Street and Number 30 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life/"IJO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) ome A: Be 17. Father's Name (Fjrst, Middle, Last ပ္ 19a. Inform nt's Name/Relationship (Street and Number or Ru Injury or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Dowatton Signature of 23a. /art/. Enter no disease, or complications that caused the death. sp ck, or hear failure. List only one cause in each line. In the diate Cause (Final prease or condition esulting in death) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Renal Failure **Physician** /Medical Examiner Sequentially list conditions, it as y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a conse-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ⋧ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performen? Yes 2/2/No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2) No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

should be

Pages 1

permit.

he Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and ipletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title

6 ☐ Could not be

Nithin To th	COM
7	V
	S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

and manner stated.

TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number October 15 2009

Sinai Hospital of Balto. Balto, MD 21215

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

for State

State of Maryland / Department of Health and Mental Hygiene amend #10e Per FH G896 69/13/14/29 of Death Red. No. 2009

34863

			Registrar		ermoate or	Julii	H	eg. No.		
	Physicia /Medic		1-1/1/	ELL			2. Date of Deat Month OCT	Day Year 23 2009	3. Time of Death 2:00 PM	
	Examin	er	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL			Location of Death		4c. County of Death		
	Funeral			e (In yrs. last birtho	tay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign	
	Director		241-34-6680 1 1 M 2 K F	87 Yr	s. Months Days	Hours Min.	(Month, Day,		NC NC	
	pu s		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	r Location				10d, Inside City Limits	
	f sho	o	MD NA	,	imore				1 □ Yes 2 □ No	
	the N	rect		Daic	10f. Zip Code		1	l 0g. Citizen of What Cou	ntry?	
	3a or	al Di	10e. Street and Number 513 Segull Ave		2]	L225		U.S.A	•	
	death	Funeral Director	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,		
36	or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ If Yes, Give	No	1 □Yes 2 ☑ No	Specify:			lack	
000	flied within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the motest Even her must be notified at	q pa	Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a D	ecedent's Usual Occup	ation		16b. Kind of Business/li		
7.	n 72	Completed	(Specify only highest grade completed)	(6	Give kind of work done of the contract of the	during most of work		lob. Kind of Eddiness/madstry		
212	d with giene er tha	Com	7th Grade College (1-4or 5	(+)	Homemaker	:		House		
pu	e file tal Hy d othe	Be (17. Father's Name (First, Middle, Last)					e, Maiden Surname)		
yla	ould to	မ	Henry Turner			Mary Ja				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the model Even her coust be puffled a once.		19a. Informant's Name/Relationship (Type. Print) John Russell Jr-Son	19b. N	Address (Street OS Wedgev	and Number or Run Jood Roa	al Route Number .d, Bal	r, City or Town, State, Z timore, M	d 21229	
ore	es 1 sof He		20a. Method of Disposition **DBurial 2	20b. Place of D cemetery,	isposition (Name of crematory or other plac	ce)	Date	20c. Location - City or T	own, State	
Ē	. Pag tment tant: jury c		4 Donation 5 Other (Specify)	King M			29/09	Woodlawn	, Md	
3aii	Depar Mpor mpor any In		21. Signature of Funeral Service Licensee	. L .	March F/F	ss of Eacility West	D - 1 4 4	E M = = = = =	21215	
	202.00		23a Part 1 Enter the disease or complications that cause	the death. Do no					21215 Approximate Interval Between	
	N		23a. Par 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lil		AL FAIL	LID E	or roophatory and		Interval Between Onset and Death	
y whose	Physician /Medical		Immediate Cause (Find disease or condition resulting in death)	a consequence of)						
	Examiner		SEVE		METABOL	IC AC	IDOSI.	S		
	2 ±	Examiner	coules Enter Underlying	a consequence or)		0.1.1.45	150	a : a		
	xecute and I-trans	xam	that initiated events	Y TRAC	T INFECT	ION WITH	1 SEPS	515		
60,	be es sician buria		500.10 (61.00	a controduction of	•					
Box 68760,	ifficate g phy: as the	an/Medical	a							
ŏ	th cerr endin	M/m	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome 1 □ live birth		3 ☐ Ectopic pregnanc	ev		23d. Date of deli		
о В	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physicia	1 Yes 2 No 4 Pregnant a		5 ☐ Other (specify) _	-		Month	Day Year	
<u>~</u> .	w requires that the de s been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death b	ut not resulting in t	he underlying cause giv	ven in Part I.	23e. Did to	bbacco use contribute to	the cause of death?	
ds,	lires t signe d be c	Completed by	CORONARY ARTERY DISE	_	,g g		1 □ Y	res 2 No 3 Pro	obably 4 Unknown	
CO	w requ	lete					24a. Was a	an 24b. Were au	topsy findings available	
Re	he lav e has age 2	Jmp					autop	sy prior to o med2 death?	completion of cause of	
ta	ician: The lav certificate has ector, page 2	Be C	25. Was case referred to medical			26. Place of Deat			2,4,100	
>	Physici this ce al direc		examiner? 1 ☐ Yes 2 XNo Hospital: 1 Inpatie	ent 2 ER/Outp	atient 3 DOA Oth	ner: 4 Nursing Ho	ome 5 Resid	lence 6 ☐ Other (Spec	cify)	
o uo	Attending Physician: The law requires that the death certificate be executed er death. er death. by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.	tion:	27. Manner of Death 1. ■ Natural 5 Pending 2 Accident investigation 28a. Date of Inju (Month, Date of Inju (Mon	ıry 28b. Tir ıy, Year) Inji	ury Wor	ry at k? IYes 2 □ No	28d. Describe h	ow injury occurred		
É	l or Attend after death. Director: / I in by the f	Certification: To	3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (S City or Tow	Street and Number or Runn, State)	ral Route Number,	
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and						
	o the	Mec	29b. Signature and title of certifier	aleu.	29c. Licens	se number		29d. Date signed (Monti	n, Day, Year)	
	- 5 - 0		M.D		RES	5000		OCT, 23,	2009	
	(5)		30. Name and address of person who completed cause of c	leath (Item 23a) (T	ype, Print)	0				
	1/		SYED MUSTAFA AHMED		HANOVER S	St, BALTI	MORE,	MD 2122	· つ	
	Sta Registr			rar's Signature	hade					
DUI	MH 17 Rev 1/2	001		10	7					

			For State Registrar		f Marylan	-	artment of F				Reg. N2 0	09	34864
	Physicia	an	Decedent's Name (First, Middle							2. Date of De	oth 20,20	Year	3. Time of Death 6:30 A M
	/Medic		Kenneth J	Richards			4b. City, Town, o	- Loostian o		ctober		ity of Death	0:30 A W
}	Examin	er	4a. Facility Name (If not institution	give street and nu	mber)		Rockvill		Death			gomery	7
			Hebrew Home 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		24 Hrs.	8. Date of Birl	h	9. Birthp	lace (State or Foreign
	Funeral Director		219-98-2703	1 🔀 M 2 🗆 F	44	Yrs.	Months Days	Hours	Min.	$\stackrel{ extit{(Month, Da}}{ ext{uly}} 11$, 1965	Washi	ngton DC
	200		Usual Residence of Decedent									1.	
-	show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					,	0d. Inside City Limits 1 √X es 2 □ No
	8a-f s	Directo	Maryland Montgo	mery	Rocl	kville	101 = 0 1				10g. Citizen o	4 18/hat Caus	
	a or 2 be n	Ë	10e. Street and Number 6121 Montrosse	D.1 #2100	Carron	Couth	10f. Zip Code 20832			1	United		•
į	is 23	Funeral	11, Marital Status						ain? (Spec			ace - Americ	
_]	riter riter iner	ᇤ	1 ☑Never Married 2 Marri	ed 1 ☐ Yes	edent Ever in U orces? 2[X]No		Was Decedent of H		ĭ, Puèrto F	Rićan, etc.)		lack, White,	
21213-0030	be fleet within 72 nouts arer death with the Maryland tall Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve ates:		1 ☐ Yes 2 🖾 No	Specify:			Spec	oify: Bla	ick
ף ה	72 no natui dical	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during mosi	t of workin	g	16b. Kind of		•
v :	Me .	du	Elementary/Secondary (0-12)	College (1-4or 5+)			d) -			Departi Agricu		Ĭ
7	med within Hygiene. Ither than " ent, the Me	ပိ	Twelth 17. Father's Name (First, Middle, 1	None		Jani	tor	18 Mothe	r's Name		Maiden Surn		
Maryiand	ed of) Be	Tommy Richardso							Turner		···· -,	
<u> </u>	mark matik	٤	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Numbe	er or Rurai	Route Numb	er, City or Tow	vn, State, Zip	Code)
1	nd 2 stath at 27 is rtrau		Anthony Richard	son/Brotl	ner	#50 I	eSellum	Ave	Gaith	ersbur	g MD 2	0877	
ē.	item		20a. Method of Disposition		20b. I	Place of Dispo	osition (Name of matory or other pla	ce) (Octob	er 30,	20c. Locatio	n - City or To	own, State
Ĕ,	nent ment ant: II		1 ⊠ Burial 2 □Cremation 4 □Donation 5 □ Other (<i>S</i>				Cemetery		2009	_1	Waldor	-	-
balumore,	permit. Pages 1 and 2 should be lifed will be partment of Health and Mental Hygien Important: If item 27 is marked other this any Injury or other traumatic event, the once.		21. Signature of Funeral Service	Licensee Dona	ald Gra	,	2. Name and Address						al Home Inc)20
F	hysician /Medical		23a. Part1. Inter the disease, or shock of heart failure. List Immediate Cause (Final disease or condition resulting in death)	only on cause on a. Ad	each line. Janced	mu	er the mode of dyi				rrest,		Approximate Interval Between Onset and Death
	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to	(or as a consection of the con	quence of):							
.O. BOX	ne death certind the attending p shed for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	1 ☐ Live	tcome pf pregn birth 2□Fet nant at time of nown	al death 3	⊒Ectopic pregnanc □ Other <i>(specify)</i> _	у				Date of deliv Month	ery Day Year
ras, r.	quires that the de n signed by the a uld be detached f	by	Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the u	nderlying cause giv	en in Part I			obacco use c Yes 2 □ No		the cause of death? bably 4 ⊠Unknown
II Kecords,	hysician; The law require is certificate has been significate, page 2 should b	Completed								24a. Was auto perfo 1∐ Yes		b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 ☑ No
VITAI	ician; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			l Ott			(Check only			
0	Phys this aldir	2	1 ☐ Yes 2 10 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatie	nt 3 DOA	4 CN NL			dence 6 🗆		fy)
0	ding l	io	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	g (Moi	nth, Day Year)	Injury	Wo	rk?]Yes 2□		od. Describe	now injury oo	Janea	
Division or	To the Hospital or Aftending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, r	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be 28e. Plac	e of injury - At h ding, etc. <i>(Sp</i> ec	nome, farm, st ify)	reet, factory, office		2	28f. Location (City or To	Street and Nu wn, State)	ımber or Rur	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical (29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Physician: To the Examiner: On the and ma	e best of my kn basis of examin nner stated.	iowledge, dea nation and/or in	th occurred at the t nvestigation, in my	ime, date ar opinion, dea	nd place, a ath occurr	and due to the ed at the time	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. Licen				29d. Date siç	ned (Month	, Day, Year)
			mina 7	arh: N	lina F	azlin	ND DO	1064	87	1	10/20	109	
			30. Name and address of person				Print) R	1064 1cvill		WD 3	L0852)	
	0.	ate	31. Date filed (Month, Day, Year)		Registrar's Sigr	-	a del	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		<u>.</u>			

09-08154	
Tammy Ray	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate	e of Death	h			Reg. No.	200		
Physicia edical Examir	ın/ ner	Decedent's Name (First, Middle,Las Tammy Ray						2. Date of De Month October 2	Day 20, 200		3. Time of Death]
		4a. Facility Name (if not institution, giv 1948 Chipper Drive			Edgev	wood	ocation of De		H	County of Deatl arford		
Funeral Director			7. Age (In y	rs. last birthda	Months Yrs.	er 1 Year s Days	If Under 24H Hours M	Hrs. 8. Date of B		Forei	thplace (State or gn puntryMary1a	ınd
rland -f show any once.	Jr.	Usual Residence of Decedent		City, Town or I	Location dgewood						10d. Inside City	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1948 Chipper Dr	ive		10f. Zip	Code 21040)		10g. Citiz	zen of What Cou USA	intry?	
r death with or items 23	Funeral	11. Marital Status 1 Never Married 2 Married	1 Yes 2 X	No	If Yes, specif	y Cuban, I	Mexican, Pue	Specify Yes or Nerto Rican, etc.)		White, etc.	rican Indian, Black	ζ,
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	eted by	15. Decedent's Education (Specify o	College (1-4 or 5+)	d) 16a. Dec	Yes 2 cedent's Usual ving most of wor	Occupation king life. I	n (Give kind		16b. K	Specify: what will will be with the windown with the wild be will be with the wild be will be with the wild be will be with the wild be will be with the wild be will be with the wild be will be with the wild be will be with the wild be will b	nite /industry	
D 21215-0036 should be filed within 73 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be Comple	12 17. Father's Name (First, Middle, Last		<u> </u>	omemake	2 E		ame (First, Middle	, Maiden	Surname)		
MD 2121: Id 2 should be fil Idth and Mental I m 27 is marked aumatic event,	ToB	George Joseph Re	EINTEIGET Type, Print)	191	_		and Number	or Rural Route N	umber, Ci	ity or Town, Stat		
		John Ray/spouse 20a. Method of Disposition 1 Burial 2 Cremation 3 4 X Donation 5 Other Specify	Removal from State	20b. Place of D	Disposition (Name or other place)	ne of cem)	etery,	Date	20c. I	Location - City o	or Town, State	
Baltimore permit. Pages 1 Department of F Important: If injury or other	Ì	21. Sign ture of Funeral Service Licer	Wan Wirect					rd 655 V				
Physician /Medical Examiner		fail re. List only one cause on each line. Immediate Cause (Final disease a. Cardiac arrhythmia associated with cardiomegaly									Approximate I Between Ons Death	et and
A. Jak	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer									
cuted und transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					-			
e execian a	Medical E	M UNPENDED	AMENDED 23a,2		ME g897	11/1	13/09	rt				
Box 68760 e death certificate b the attending physical for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time g Unknown	2	Fetal death Other (Spe		Ectopic pre	egnancy	23	d. Date of delive	ery Day Ye	ear
ires that the d signed by the	by	Part II. Other significant conditions	contributing to death but	not resulting in	n the underlying	g cause gi	ven in Part I.				to the cause of dea obably 4 🗸 Uni	
cords, law require has been si 2 should b	Completed							pe 1 ✔ Ye	as an topsy rformed? s 2 N	prior to death?		vailable use of No
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital:	2 FD/0			Othor:	eck only one) ursing Home 5	Posid	ence 6 🗸 Oth	ner: Scene	
on of Vi nding Physi th. r: After this re funeral dir	ပ္	1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)			28c. Injur	y at Work?	28d. Describ		jury occurred		
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the far	ertification:	2 Accident Investiga 3 Suicide 6 Could no determine	t be 28e. Place of Injury	- At home, farn	n, street, factory	y, office bu	uilding, etc.		n (Street a n, State)	and Number or	Rural Route Numb	er, City
To the Hospital within 24 hours To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Physic	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death tion and/or inv	occurred at the	e time, da	te and place, death occurr	and due to the cared at the time, da	ause(s) ar	nd manner as si lace, and due to	tated. the cause(s)	
7.87.8	Me	29b. Signature and title of certifier	itle of certifier 29c. License number 29d. Date signed (#									
		30. Name and address of person who Ling Li, MD Assistant N			Street, Balt	imore, N	MD 21201					
	State 31. Date filed (Month, Day, Year) 2009 37 Registrar's Signature											

			For State	State of Mary		artment of F		/lental Hyg	iene eg. No 2009	34866
			Registrar 1. Decedent's Name (First, Middle, Las	st)		inoute or	Dealit	2. Date of Deat		3. Time of Death
	Physici		William Barb		dean			Month 10	26 2009	1:15 p ^M
-	/Medic Examir		4a. Facility Name (If not institution, give		43011	4b. City, Town, o	r Location of Death		4c. County of Deatl	
	Exami	ei	Manor Care Dulan	ev		Towso	n		Baltimo	re
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9. Birti	nplace (State or Foreign
	Director		212-56-4336	XM 2□F	59 Yrs.	Working Days	Tiodis Iviii.	2 15	1950	MD
	and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	faryle f sho	ō								1 XYes 2 □ No
	28a-	Director	MD 10e. Street and Number		Baltimore	10f. Zip Code		1	0g. Citizen of What Co	untry?
	3a or	Ö	3102 Mondawmin	Δνα		2121	6		U.S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
ဖွ	or ite		1 ☐ Never Married 2 Married	Armed Forces? 1 ∐Yes 2 M No If Yes, Give		n Yes, specify Cuba 1 □ Yes 2 🇷 No	Specify:	nican, etc.)	Black, White	
003	ours iral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					B1	ack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Evarinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work		16b. Kind of Business/	ndustry
12	withir ene. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		eacher	υ)		Educatio	n
	Hygi Hygi Sther ent, t	Be C	17. Father's Name (First, Middle, Last)	_		achei	18. Mother's Nam	e (First, Middle, M		
lan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinar must be notified at once.	D B	William P. Richar	rdson			Sarah	Barber		
Maryland		-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	r, City or Town, State, 2	ip Code)
2		3	Carla Johnson		310	02 Mondaw	min Ave.		ore, MD 212	
ore			20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐	Removal from State	 Place of Dispo cemetery, cren 	sition (Name of natory or other plac	ce)		20c. Location - City or	
Ë	Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specification)	v) 1		ney Cremato	ry = 10/2	8/2009	Woodbine,	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	Dorota Ma	rshall 22	2. Name and Addre	oss of Facility Mar O. Box 14	ryland Ci 113 Balt	remation Se timore, MD	21203
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only					Approximate Interval Between		
1	Physician	8 1	Immediate Cause (Final disease or condition	Severe	Athonos	clerote	Condi	o vasul	Pardisease	Onset and Death
	/Medical		resulting in death)	Due to (or as a co						
	Examiner	L	Sequentially list conditions	b. Dreft		Mitny				10401
	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co		lune, c	A.van			5 Yest
	and al-tran	xan	that initiated events resulting in death) Last	c. Due to (or as a co		ine c	70010			2 100
8760,	cate be executed physician and the burial-transit			٠.	. ,					
687	ifficate g phy as the	edic		d.						
Box	leath certifii attending p for use as	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		7 Catania avo anan			23d. Date of de	ivery
Э.	deat ed for	sicia	in the past 12 months? 1 □Yes 2 □ No	4 ☐ Pregnant at time		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _			Month	Day Year
P.0	res that the de signed by the a be detached to	Physician/Medical	9 Unknown					OO Dida		Also serves of death?
s,	res th signed be de		Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to es 2 □ No 3 □ Pi	robably 420nknown
of Vital Records,	w require been sign	Completed by								
3ec	has t	ng l						24a. Was a autops perfori	sy prior to	itopsy findings available completion of cause of
a	sician: The certificate h rector, page							1 □ Yes	2.MgNo 1. ☐Yes	2 □ No
Vit	sician certi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital:	0 CT ED/O 4 - 4'-	Oth		th (Check only on		
of	ding Phys h. After this funeral dir	Ĕ	27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time o	f 28c. Inju	ry at		ence 6 ☐ Other (Spe ow injury occurred	city)
ion	ath. :: Afte	aţio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ar) Injury	M 1 🗆	rk?]Yes 2□No			
Division	I or Attendi after death. Director: A I in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number or Ri	ural Route Number,
Ö	ital or irs aft ral Di	Cer		Sanding oto. (
	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		nysician: To the best of m niner: On the basis of exa and manner stated.						
	Vithir comp	Me	29b. Signature and title of certifier	/		29c. Licens	se number	2	29d. Date signed (Mont	h, Day, Year)
			1 mior-B	1 Kloup,	MO	0	3/865		10-2	7-09
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	REOT		10-2 Ma 212	
			31. Date filed (Month, Day, Year)	32 Registrar's		- 1	ward in	126	Ind Ho	1
	Sta	ite	Of United (World, Day, Teal)	MO SZA TOGISTIALS	1	Rollad				

DHMH 17 Rev 1/2001

		For Amend Item 25 per Registrar 1. Decedent's Name (First, Middle, Last)	e of Maryland / Departm r verb., g896, 10/29 Certific	cate of Death	2. Date of Death	3. Time of Deat
Physicia /Medic		Tall 1	AWLINGS		Month (2009 02:11 A
Examin		4a. Facility Name (If not institution, give street an		City, Town, or Location of Death		c. County of Death
Funeral Director		HOWARD COUNTY GE 5. Social Security Number 6. Sex 1 M 2 Usual Residence of Decedent	7. Age (In yrs. last birthday) If U	nder 1 Year If Under 24 Hrs. this Days Hours Min.	8. Date of Birth (Month, Day, Yea 7/2/19	
f show	tor	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Lir 1 XYes 2 □
3a or 28a at be notif	al Director	10e. Street and Number 3812 Hirlem Aven	10	f. Zip Code 21259	10g. (Ditizen of What Country?
natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	res 21XINo	Decedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto es 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
ne. nan "natura Medical B	Completed	15. Decedent's Education (Specify only highest grade completed in the complete in the comp	ited) (Give kind o	Usual Occupation of work done during most of work of use retired)	ing 16b.	Kind of Business/Industry
Mental Hygiene. arked other than atic event, the Ma	Be	17. Father's Name (First, Middle, Last)	Lisae	18. Mother's Name	e (First, Middle, Maide	I VU NS FOTTU 110 カ en Surname) つ
Health and em 27 is m ther traum	o L	19a. Informant's Name/Relationship (Type. Print) Hothe G. Rawlings 20a. Method of Disposition	Wife 38/12 H	dress (Street and Number or Rur Number of Avenue (Name of proper place)	Baltim	y or Town, State, Zip Code) No. Maryland 215 Location - City of Town, State
Department of Important: if it any injury or oonce.		1 Surial 2 □ Cremation 3 □ Removal id □ Donathon 5 □ Other (Specify) 21 Signature Fruneral Service Licensee	Louden Pa	LPK 10/16 ne and Address of Facility hn (! Chiene !	. 12009 PA	attimure, Marylan - York Road Shove, Maryland
ysician Medical		23a. Part1. Enter the disease, or complications is shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Do not enter the on each line. SEPSIS let to (or as a consequence of):	mode of dying, such as cardiac	or respi ra tory arrest,	A croximate Interval Betweek Onset and Deat
physician and it the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ASPIRATION P a to (or as a consequence of): THE ROSCUER ONC e to (or as a consequence of):	CARDIAC D	ISEASE.	
ned by the attending physicion detached for use as the bu	Physician/Medical	in the past 12 months?		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
been signed should be de	þ	Part II. Other significant conditions contributing	to death but not resulting in the underly	ing cause given in Parţ I.		o use contribute to the cause of death
ate has page 2	Completed				24a. Was an autopsy performed 1 Yes 2 □	
offer this	on:To Be	1 Natural 5 ☐ Pending	1 inpatient 2 ER/Outpatient 3 [Date of Injury (Month, Day, Year) 28b. Time of Injury	DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how in	6 ☐ Other (Specify)
deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. I	Place of Injury - At home, farm, street, fa building, etc. <i>(Specify)</i>		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
within 24 hours after To the Funeral Dire completely filled in b	Medical ((Check only 2 Medical Examiner: On	o the best of my knowledge, death occ the basis of examination and/or investig manner stated.			
	ž	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
with To t				DSD404 UXENT PKM		C1. 11, 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:18 AM ROXANNE 2009 SERVANCE $^{\prime}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE, UNIVERSITY MEDICALIENTER MI BALTIMORE OF MARY LAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 216-52-259 1 □ M 2 🗗 F Carolina 950 Director South Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination matter rolling at 1 1 Yes 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. lack 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) th and Mental Hygiei 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ ervance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an orthquite mother Health a MD21218 Servance 14 more other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dațe 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Surial 2 ☐ Cremation 3 Removal from State altimore 4 ☐ Donation S Other (Specify) 22. Name and Address of Facility uneral Service Lidense Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC BREAST YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed the burial-tran that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) s been signed by the s should be detached Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown HUART 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I autopsy page performed death? 1 □Yes 2 HNO 1 ☐ Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation iours after death. neral Director: A filled in by the fu 2 DAccident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 128586 9149 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAKT1 MD MARYLAND, 22 S. GRETNE ST, BALTIMURE, IND NAYAR UNIV OF 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e, per Fh. 8896 10/30/09 TT

Amend 10e, per Fh. 8896 10/30/09 TT

			1- State Registrar	āte of Māryla		artment of F rtificate of a		lental Hyg	iene eg. No. 2009	34869
	44.63		Decedent's Name (First, Middle, Last)					2. Date of Deat	n	3. Time of Death
	Physicia /Medic		Margaret Lee	Si	sson	Scher	nk	October	23, 2009	1:55 PM
	Examin		4a. Facility Name (If not institution, give stree	t and number)			r Location of Death		4c. County of Dea	
. •			3701 Astoria Road			Kensi	ngton If Under 24 Hrs.		Montgome	
	Funeral Director		5. Social Security Number 6. Sex 1 M		s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 7,		thplace (State or Foreign ountry) rginia
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	Maryi -f sho	ţō	MD Montgomery	Κe	ensingto	on				1 □Yes 2 XNo
	or 28a	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	ountry?
	th wit	a	3701 Astoria Road		20895 USA					
36	filed within 72 hours after death with the Maryland Hygene. Phygene other than "natural", or items 23a or 28a-f show ent, the Predict Evanimer must be notified at	by Funeral Director	1 Never Married 2 Married 1	/as Decedent Ever in rmed Forces? □Yes 21 No Yes, Give	'	Was Decedent of H f Yes, specify Cuba I □Yes 2 ☑ No	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
Ş	hours tural"	q pe	3 KJ Widowed 4 LJ Divorced Y	ear or Dates:	160 Dogg	dent's Usual Occup	oction		16b. Kind of Business	hite
21215-0036	vithin 72 ene. :han "na!	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Give life. I	kind of work done OO NOT use retired	during most of worki d)	ng		'
2	filed w Hygie ther t	ပ္ပိ	17. Father's Name (First, Middle, Last)		Se	cretary	18. Mother's Name	(First, Middle, N	Tax Servi	.ce
Maryland	permit. Tages I ain 2 should be filed within 7.2 flouts after beath with the waynan permit. Fages I halth and Mantal Hygiene. Important: If item 2.7 is marked other than "natural", or items 2.3a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Everette S. Sisson					n Mundy	iai a a i i a i i a i i a i i a i a i a	
ary			19a. Informant's Name/Relationship (Type. F	rint)	19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)
Ξ	and 2 ealth a n 27 is er tra		Sherrye Schenk - Da	aughter	3701	Astoria	Road Kens	ington,	MD 20895	
altimore,	les 1 of He if item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Remove	20b	Place of Dispo cemetery, cren	sition (Name of natory or other plac			20c. Location - City or	
Ē	t. Pag tment tant: jury o		4 □ Donation 5 □ Other (Specify)	Si	-	Crematory			Roanoke, V	irginia ———————
Rai	permii Depar Impor any ir once.		21. Signature of Funeral Service Licensee	dle			ss of Facility uneral Ho rs Creek		noke, VA	24019
			28a. Part 1 Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the de use on each line.	ath. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
4	hysician		Immediate Cause (Final disease or condition resulting in death)	Metastati	c Cance	r in Peri	itoneum			Onset and Death months
1	/Medical Examiner		resulting at deathy	Due to (or as a conse	equence of):					
		ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c							
Ď,	e exe	EX	resulting in death) Last	Due to (or as a conse	equence of):					
58760,	icate be executed physician and the burial-transit	dical	d							
	death certif e attending d for use as	Physician/Me	in the past 12 months?	yes, outcome of preg ☐ Live birth 2☐ Fe ☐ Pregnant at time o ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	livery Day Year
7.	nat the d by t etach	Phy	9 Unknown Part II. Other significant conditions contribu		aculting in the	adad ing sauga siy	van in David	230 Did toh	pacco use contribute t	o the cause of death?
Records,	requires that the leen signed by th nould be detache	ted by	Dementia	ung to death but not re	esalting in the ui	denying cause giv	en in Part i.			robably 4X Unknown
Hec	The larate has	Completed						24a. Was ar autops perforn 1 🗆 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
Vital	Physician; The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ral·		Oth	26. Place of Death	77	4	
=	hys igin	۲: ا	1 res 2 140	a. Date of Injury	☐ ER/Outpatier 28b. Time of	IT 3 LI DOA	4 LI Nursing Ho		nce 6 ☐ Other (Spewinjury occurred	ecify)
0	th. : Afte : fune	ition	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)		Wor	k? Yes 2 □ No	Edd. Describe no	w injury occurred	
DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	ertification:	a Could not be	e. Place of Injury - At building, etc. (Spe	home, farm, stracify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
	e Hospita 124 hours e Funera letely fille	Medical C	29a. Certifier 1 Certifylng Physicial (Check only one) 1 Medical Examiner:	n: To the best of my k On the basis of exami	nowledge, death ination and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
_	Vithii Comp	Me	29b. Signature and title of certifier)112900	De mi	29c. Licens D3820			9d. Date signed (Mon October 27	
	(H)		30. Name and address of person who comple Anurita Mendhira	,		Print) earch Blv	vd. Rocky	ville, M	D	
9	Sta Registr	-	31. Date filed (Month, Day, Year) QCT 3 0 2009	32. Registrar's Sig				,		

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

THORT

31. Date filed (Month, Day, Year)

R ..

ER DRIVE.

TOWSON.

MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

2. Registrar's Signature

		1	For State Registrar	State of Maryland		rtment of F		Mental Hyg	giene Rea. No	2009	34871
	siciar edica	ו	1. Decedent's Name (First, Middle, Last	E. Shell	eu	_		2. Date of Dea		Year	3. Time of Death
Fune Direc	eral	r	a. Eacility Name (If not institution, give 5. Social Security Number 6. Security Number 10-10-095 Jual Residence of Decedent	street and number) CRUS 7. Age (In yrs. las	et birthday) Yrs.	4b. City, Town, o	r Location of Death PHAL If Under 24 Hrs. Hours Min.	8. Date of Birt	h y, Year)	Cou	Place (State or Foreign intry) KTON MD
the Maryland	nomined at		Oa. State 10b. County	MORE 10c. City,	Town or Loc	ation ONKtor 106. Zip Code	U		10g. Citi:	zen of What Cou	10d. Inside City Limits 1 □ Yes 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Financial Di	2	527 G : FFORM 1. Marital Status 1. Never Married 2. Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give		as Decedent of H Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		USA 14. Race - Ameri Black, White,	etc.
1215-0036 vithin 72 hours aft sne. than "natural", or	t, the medical evan	mpleted by	3 Widowed 4 □ Divorced 15. Decedent's Ed. (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates:	16a. Deced	ent's Usual Occup ind of work done O NOT use retired	pation during most of wor d)	king	16b. Kii BAL	Specify: Wf nd of Business/Ir TMORE PARKS	ECO. DEPT
Maryland 212 Id 2 should be filed with the and Mental Hygiene. T is marked other than	To Be Co	1	17. Father's Name (First, Middle, Last)	SHELLEY	7 800	1DSKE	18. Mother's Nan		Maiden	Surname) Ur	TKNOWN
imore, Mal Pages 1 and 2 st nent of Health and int: If item 27 is n	or other traum		19a. Informant's Name/Relationship (7) ARK SHE((a) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Ey - SON 20b. Placen cen	527	Address (Street	and Number or Ru	Monk Date	100 20c. Lo	MD c	2//// own, State
Baltimore, permit. Pages 1a Department of Hee	any injury		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Livens Continue Lechotry	EVO	ins FUN	exal Cha	pel+Cre	.Rd.,		MD 21111. MCES-Monkfo Approximate	
Physici /Medi Examir	cai ner		shock, or heart failure. List only a Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequent)	Sy	NHA	- I	or roophatory an			Interval Between Onset and Death
isate be executed physician and	dical Evaminar	ŭ	Sequentially list conditions, if an, leading it imm is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of details of the consequent of the con	,						
Geath certif	ian/Ma	iyəlci aliyliyledi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗌	Ectopic pregnand Other (specify)	·y		2	23d. Date of deliv	very Day Year
	ž	2	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the un	derlying cause giv	en in Part I.	23e. Did to	1	_	the cause of death?
Vital Records, slcian: The law requires the certificate has been signed reader page 2 should be detailed by the certificate of the certificate has been signed by the certificate of the	Comp	ע	25. Was case referred to medical examiner?				26. Place of Dea	24a. Was autop performed 1 Tes	rmend? 2 No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
on of ding Phy After this	of reci	2	1 Yes 2 No. 27. Manner of Death 1 Natural 5 Pending investigation		R/Outpatient 8b. Time of Injury	28c. Injui Wor	4 PU Nursing F	lome 5 ☐ Resident Re			ify)
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director. After Completely filled in by the fine	and the discussion.		3 Suicide 4 Homicide 3 Suicide 4 Could not be determined	28e. Place of Injury - At hombuilding, etc. (Specify)	edge, death	occurred at the ti	me, date and place	City or Tow	vn, State,	and manner as	ral Route Number,
To the Ho within 24 To the Fu	Medical	Medic	(Check only 2 ☐ Medical Examone) 29b. Signature and title of certifier	Iner: On the basis of examination and manner stated.	n and/or inv	29c. Licens				e signed (Month	
,		4	30. Name and address of person who of	ompleted cause of death (Item 2	3a) (Type, F	rint) Leforf	w		w	NOIO	
Rec	State jistrar		31. Date filed (Month, Day, Year)	2009 Registrar's Signatur	· A.	barker					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per MD 2896 10/30/09 TT State of Maryland / Department of Health and Mental Hygiene Amend #1, per 1 - For State Registrar Reg. No. 2009 34872 Certificate of Death 1. Decedent's Name (First, Middle, Last) Ronald Wayne Smith 2. Date of Death OCTOBER **Physician** 4:08 a.M 2009 Nonald /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and num 4c. County of Death Examiner Johns HOPKINS Baltimore HOSPItal 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 3 M 2 □ F Director 1946 Maryland 15. 214-46-3973 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show r items 23a or 28a-f shov 1 □ Yes 2 🔣 No Director Maryland | Harford Abingdon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? death with USA 4019 Sharilynn Drive 21009 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Tyes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 🛣 No Specify traumatic event, the Mudical Ever. 5 Specify: 3 Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) State Trooper State Government Λ is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Louise Lewis Clarence (nmn) Smith ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. Sharon Lee Roz-Smith / Wife 4019 Sharilynn Drive, Abingdon, Maryland 21009 3altimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lewis Cemetery 10-29-09 Willards, Maryland 22. Name and Address of Facility.
McComas Funeral Home, P.A. of Funeral Service License athlel 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed burial-transi and Due to (or as a consequence of) attending physician for use as the burial Box 68760. requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy certificate 1 □Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore 31. Date filed (Month, Day, Year 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07708 State of Maryland / Department of Health and Mental Hygiene Franklin Delano Sibalik 2009 34873 1- For State Certificate of Death Rea. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 4, 2009 1836 hrs Franklin Delano Sibalik Medical Examine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Perryville 406 Front Street, Perryville, MD 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number un 6. Sex **Funeral** Months Days Hours Min Director Country 49 $_{1}X$ Yrs 13 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County MD Cecil Perryville Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 606 Concord Drive 21903 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes white Yes 2 X No specify: f Yes, Give Year Specify: Widower Divorced the Medical Examiner is marked other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 hant of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Brady Franklin Delano Sibalik Sr Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other traumatic 1259 Willow Road Baltimore, MD Angelo Torre/brother in law 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: Donation 5 X Other Specify: in state uneral Service License Ronald 8 21. Signature of Funera 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ire. List only one cause on each line /Medical a Alcohol and heroin intoxication complicated by Immediate C -use (Final disease **xaminer** Due to (or as a consequence of): Cocaine use or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of)

Exami Be Completed by Physician/Medical

Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause

(Disease or injury that initiated events resulting in death) Last

and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. signed by the attending physician a be detached for use as the burial s peen s After this certificate has funeral director, page 2 sh To the Funeral Director: completely filled in by the

Medical

State Registrar

29a. Certifier (Check only one) 2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

=	d.		
dica	X UNPENDED	AMENDED 23a,27,28a-f,perME, g897 11/2/0	09 TT
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery Month Day Year
ģ		contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Completed			24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
	25. Was case referred to medical	26.Place of Death (Check of	only one)
To Be	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursin	g Home 5 Residence 6 Other: Scene
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Fd 10/4/09 Fd 6:19 pm 1 Yes 2X No	28d. Describe how injury occurred unk
Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in vehicle	28f. Location (Street and Number or Rural Route Number, City or Town (State) 406 Front St Perryville, MD
_	20a Cartifian		

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 5, 2009

unk

Death

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend item 9 per fh 8896 10-30-09 vt
State of Maryland Department of Health and Mental Hygiene 2009

Certificate of Death Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) October 27, 2009 **Physician** Hulda Svare Sorensen 6:35 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 14720 Pettit Way Montgomery Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 24, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** North Dakota 1 □ M 2X F Yrs. 1922 87 Director 501-14-1576 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at Yes 2 ☐ No Director CA San Mateo San Mateo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 94403 678 West 30th Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White þ 3 XWidowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 <u>Secretary</u> 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olaf Svare Ida Olson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Karen Sorensen Staines/daughter 14720 Pettit Way Potomac, MD 20854 Department of Health Important: If item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 10/30/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Going Modes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Gastric Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause i Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed after death. physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy performed' 2□No 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Yother (Specify) home Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 🗆 Yes 2 No neral Director; / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63195 October 27, 2009 MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilks, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

30

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:45 AM Naomi Louise Stevens 2009 October 26, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Timoníum <u>Stella Maris</u> If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 01/28/1918 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** West Virginia 1 □ M 2 🗓 F 91 Director 214 12 1029 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 To No Director Baltimore Timonium Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21093 2300 Dulaney Valley Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married $11:45~\mathrm{A.M}$. Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: δ White 3 → Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: If item 27 is marked other the any linury or other traumatic event, u. s. once. Homemaker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Meyers Bessie Long ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Morgan / Granddaughter 9103 Crosshill Road Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 10/28/2009 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 namerousk 23a. Part 1. Enter the disease, or corplications that caused the docth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If st. any one cause on each line. Approximate Interval Between Onset and Death 05/150515 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): DOMI. STEVENS DECORDS, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not requiting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown estate. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Urrsing Home 5 Residence 6 Other (Specify) After this Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ural 2 Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature ape title of certifier 29c. License number OCTOBER 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 0CT 3 0 2009 32. Registrar Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	faryland / Depa <i>Cel</i>	artment of F rtificate of a			2009	34876
	Physic /Med		1. Decedent's Name (First, Middle	5.		Soto		2. Date of Death Manth PLIDEA	Day Year 23, 2009	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution) Harbor Hospita		r)	4b. City, Town, or Baltim	r Location of Death	4c. County of Death		
	Funeral Director		219-62-6159	6. Sex 7. A 1 □ M 2 M F	ige (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y December 2	(ear) 9. Birthp	
	ryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			1	0d. Inside City Limits
	the Ma	Director	Maryland N/A	<u> </u>	Baltimore	10f. Zip Code		100	. Citizen of What Coun	1 Kes 2 No
	23a or	ral Dì	1827 Westphal Pla	œ		212	30	, rog	U.S.A.	iu y :
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Fedical Evernitation in a rollfied at any once.	by Funeral	11. Marital Status 1 Never Married 2 M Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates] No	Was Decedent of H fYes, specify Cuba l □Yes 2 🛣 No	ispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, 6 Specify: Whit	etc.
21215-0036	within 72 ho liene. r than "natu i ne Medical	Completed	15. Decedent (Specify only highes) Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+) (Give life. L	dent's Usual Occup kind of work done o DO NOT use retired Lice Manager	during most of working f)	7	b. Kind of Business/Ind Southern Sta	•
and 2	be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, L John Lycett	<u> </u>			18. Mother's Name	First, Middle, Ma	iden Surname)	
Baltimore, Maryland	2 should and Mei is marke	은	19a. Informant's Name/Relationsh						City or Town, State, Zip	Code)
re, ≥	tem 27		Robert Soto Sr. 20a. Method of Disposition	(Husband)	20b. Place of Dispo- cemetery, cren		Place, Balti		yland 21230 c. Location - City or To	wn. State
timo	Pages tment or tant: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Holy Cross	_			ooklyn Park, 1	
Bal	permit. Departi		21. Signature of Funeral Service L	cersion	Internal Mo	Name and Address Cully-Polyr	niak Funeral	Home P.A.	1 01000	
	Physician /Medical		23a. et 1. Enter the disease, or or prock, or heart failure. List of influediate Cause (Final disease or condition resulting in death)	a.	ed the death. Do not enter line.	er the mode of dyin	g, such as cardiac or	respiratory arrest	aryland 21230	Approximate Interval Between
	Examiner		Sequentially list conditions,	Due to for as	s a consequence of):					
X	cuteo nd ansi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of):					
38760,	cate be executed physician and the burial-transi	dical Exa	resulting in death) Last	Due to (or as	s a consequence of):					
O. Box (death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy	1		23d. Date of delive Month	ery Day Year
ords, P.	law requires that the das been signed by the 2 should be detached	þ	Part II, Other significant condition	s contributing to death i	but not resulting in the un	derlying cause give	en in Part I.	23e. Did tobac	cco use contribute to th	
of Vital Records,	2 8 2	Completed	Seizn	re Di	, viler	•		24a. Was an autopsy performed 1 □ Yes 2	prior to cor death?	psy findings available inpletion of cause of
f Vit	ding Physician: The n. After this certificate hi funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ient 2 ER/Outpatien	t 3 DOA Othe	26. Place of Death (e 6 □Other (Specify	/)
o uo	Attending Pi er death. ector: After the by the funeral	tion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, Da	ury 28b. Time of Injury	28c. Injury Work	/ at 28	d. Describe how		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification: To	3 ☐ Suicide 6 ☐ Could no determin	t be 28e. Place of In	jury - At home, farm, stre tc. <i>(Specify)</i>			f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
ıl	To the Hospital or within 24 hours after To the Funeral Din completely filled in I	Medical C	29a. Certifier 1 IV Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis of and manner st	of my knowledge, death of examination and/or inv tated.	occurred at the tin restigation, in my of	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as stead of the second place, and due to	tated. the cause(s)
1	To th withir	Me	29b. Signature and title of certifier			29c. License			Date signed (Month, L	*
			30. Name and address of person w	111	death (Item 23a) (Type, F		ht Sh	100	timere	71270
	Sta Registr	re.	31. Date filed (Month Pay, 200)	32. Registr	rar's Signature	1	-17 01-	0)(1)	r, marc	21230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009

			1 - For Stata Registrar	,,,	Cert	ificate of	Death	Rag	. No.	0.0				
	Dhysiai	200	1. Decedent's Name (First, Middle, Last)		<u>.</u> ,			2. Date of Death Month	Day Year	3. Time of Death				
	Physici /Medio		BEARL	C. SMITH				October	19, 2009	6:19 p M				
	Examir	ner	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Dea					
	Funeral		North Arundel Health & 5. Social Security Number 6. Sex		last birthday)	Glen Bu	ITILE If Under 24 Hrs.	Anne Aru	thplace (State or Foreign					
	Director		215-22-0032	IM 2 🖾 F 92	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan 16,	1917 Fi	ountry) Lorida				
	iand iand		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loca	ation				10d. Inside City Limits				
	Many Per sh	tor	Maryland N/A			F	Baltimore			1 🖾 Yes 2 🗆 No				
	with the	Director	10e. Street and Number	yshire Road		10f. Zip Code	2123		g. Citizen of What Co	ountry?				
	ns 23	Funeral		12. Was Decedent Ever in U.	S. 13. W	as Decedent of H			14. Race - Ame	erican Indian.				
036	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "naturel", or items 23a or 28a-f show event, I're Medical Exartinal mail be notified at	by	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Yes, specify Cuba □ Yes 21☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, White					
5 - -	72 hc	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give k	nt's Usual Occup	during most of work	king 10	b. Kind of Business	/Industry				
121	within then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		phone Open		E	ell Atlanti	c Telephone Co.				
0 7	at Hygid other vent, ij	0	17. Father's Name (First, Middle, Last)	0	Tete	priorie oper		e (First, Middle, Ma	aiden Sumame)					
<u>an</u>	ould be Mental narked o	To B	Jac	cob Henry Herr			Ada Est	elle Dean						
ă Z	as 1 and 2 should to of Health and Ment of Item 27 is marked r other traumatic		19a. Informant's Name/Relationship (Type Victoria Hoffman	oe, Print) (Daughter)				ra <i>l R</i> oute <i>Number,</i> pore, Maryla	City or Town, State, and 21230	Zip Code)				
Baltimore,	Pages 1 energy of Herrory or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20c. Location - City or Town, State Marriottsville, Maryland										
Balt	1 Signature of Funeral Service Licensee Kevin E Ecker 1 Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully—Polyniak Funeral Service Licensee Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Md. 212									Home, P.A. 856				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Conset and De											
	Physician		Immediate Cause (Final disease or condition	the he	imer	is d	risees	0.		Onset and Death				
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	0- ~ 1	<u> </u>			San Out D				
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):	Ce 87/				,esco				
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ď,	icate be executed physicien and s the burial-transit		resulting in death) Last											
98/P0	ohysic the bi	Medical	€ d											
×	E D'a		IF FEMALE:	3c. If yes, outcome of pregna	ncv				004 0-4-44	P				
O. E0	w requires that the death certificate be executed been signed by the attending physicien and should be deteched for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□E	ctopic pregnancy Other (specify)			23d. Date of de Month	Day Year				
٠ <u>.</u>	that I		Part II. Other significant conditions con	tributing to death but not resu	ulting in the und	lerlying cause give	en in Part I.	23e. Did toba	cco use contribute to	o the cause of death?				
ecords,	quires an sign	ed by		Hyperte	N815	7 -		1 ☐ Yes	2,000 3 □ P	robably 4 Dunknown				
ပ္မ		piet		Mon	1 oc	ť		24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of				
ľ	The ate h page	Completed						performe	d? death? No 1 ☐ Yes	2 No				
итаі ж	ician certifi ector	Be	25. Was case referred to medical examiner?	ospital:			1	h Check only one						
Ö	Phys rat di	To	1 ☐ Yes 2 No	1 ☐ Inpatient 2 ☐ ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of	3□ DOA Oth	4 Nursing Ho	ome 5 Residen 28d. Describe how	ce 6 ☐Other (Spe	ocify)				
0	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injun Worl M 1 []	(? Yes 2 □ No	Zod. Doscribo non	injury occurred					
DIVISION	To the Hospitel or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stree	et, factory, office		28f. Location (Stre City or Town,	et and Number or R. State)	ural Route Number,				
)	e Hospit	edicai (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death of ion and/or inve	occurred at the time stigation, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as and place, and due	s stated. e to the cause(s)				
	To th withir To th comp	Me	29b. Signature and little of certifier		_ <	29c. License		290	I. Date signed (Mont	th, Day, Year)				
			112				14973	C	ctuber	21 207.				
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Pr	225	HOSPT	Tal	DRIVE,	4la Bunda				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure A		1 - 1		1	21061				
	Registr		OCT 3 0 ZUNY	Much B.	19 Char									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October **Physician** 2009 MARY TRUFFER 5:20 p M D. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Marlev Neck Health & Rehabilitation Center Glen Burnie 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 👽 F 218-42-9168 Director January 16, 1915 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2 X No Director Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7675 Pinehaven Drive 21122 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 White 1 ☐Yes 2 No Specify: δ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item \$\frac{7}{2}\$ is marked other the any linury or other draumatic event, ITAL ODGS. Homemaker 6 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ferdinand Wehberg Minnie Weidner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dolores Robison (Daughter) 7675 Pinehaven Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 10-28-09 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Fune of ervice Licens McCully-Polyniak Funral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Pa 7. Enter the disease, or complica lock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Impordiate Cause (Final ease or condition esulting in death) 0 **Physician** /Medical **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnar in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 2 NO P.0. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ pe 2 N → 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 1 No 1 □Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1000 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 2/41/60 29d. Date signed (Month, Day, Year) 29b. Signature mi title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singh M.D. 5410 A. Ritchie Highway, Brooklyn Park, Maryland 21225 Harjit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2009 Registrar

		-	= State Amend Item	State of Mar 26 per verb	ryland / [••,g896	Department of COLUMN	Health and Death	Mental Hygid Reg	ene 2009	34879
			1. Decedent's Name (First, Middle, L	ast)			1 1	2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	_	LOUISE		· ·	LATER		OCTOBER	2 24, 200	7 12:45 PM
	Examine		4a. Facility Name (If not institution, g	CK ROMO		BALT	or Location of Dea		4c. County of Dea	nore
	Funeral Director		218-72-9499	Sex 7. Age 1	(In yrs. last bir	thday) If Under 1 Yea Months Day		n. (Month, Day,		thplace (State or Foreign ountry) nslyvania
and	Α	}	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	n or Location				10d. Inside City Limits
Maryl	short	ō	Maryland Baltimo	ore		Baltimore				1 □Yes 2 No
the l	7.28a	8	10e. Street and Number			10f. Zip Code)	100	g. Citizen of What Co	ountry?
h with	23a o		602 Windwood Roa	ad		21	.212		U.S.	Α.
deat	ems (Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent of	f Hispanic Origin?	(Specify Yes or No-	14. Race - Ame Black, Whit	
1215-0036 within 72 hours after death with the Maryland	ral", or ite Evantins	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced)	1 □Yes 2 🛛 N				hite
5-0	natri	etec	15. Decedent's (Specify only highest of	Education rade completed)	16a	Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	cupation ne during most of w	vorking 16	6b. Kind of Business	/Industry
2121	than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manager	red)		Restau	rant
d 2	Hygie ther ont, th		17. Father's Name (First, Middle, La	st)		Tiuriu ge.	18. Mother's N	ame (First, Middle, Ma	aiden Surname)	
and	ked o	To Be	Harrison Filmon		Jr.		Jea	nne St.	Martin	
ary	md M mar umat	۲	19a. Informant's Name/Relationship	(Type. Print)	195	. Mailing Address (Stre	et and Number or	Rural Route Number,	City or Town, State,	Zip Code)
Sund 2	alth a		Susan Wyatt-Car	rter /Sister	4	607 Keswick	Road, B			21210
Baltimore, Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment nast be nutfilled at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		20b. Place o cemete Hillto	f Disposition (Name of ry, crematory or other p op Service	Corp. 10		Towson,	
Balti permit.	Departr Importa any inju		21. Signature of Fineral Service Lic	ensee Aud	w)	22. Name and Add	dress of Facility Road, T	Ruck Towso owson, Mar	n Funeral yland 21	Home, Inc. 204
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused t	the death. Do					Approximate Interval Between
Ph	nysician		Immediate Cause (Final disease or condition	y one cause on carrine	16,29	ATIC C	ANCE			Onset and Death
	Medical		resulting in death)	Due to (or as a			,			
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pe	sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):				ĺ
xecut	and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):				
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	g phy as the	edical		U			-		- I	-Vi-
P.O. Box (the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	☑ Fetal death	a 3 ☐ Ectopic pregna 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
Par #	signed by the a		Part II. Other significant conditions	contributing to death but	t not resulting i	n the underlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
- W &	De g	d by	BILINAY SE					_ 1 ☐ Yes	s 2 □ No 3 □ F	Probably 4 Unknown
2- 5 №	s been s	lete						24a. Was an	24b. Were a	autopsy findings available
Division of Vital Record	# CV	Completed						autopsy perform1 □Yes 2	ed2 prior to	completion of cause of
ian:	h. After this certificate h funeral director, page	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only one		
of Vita Physician:	his ce I dire	2	1 Yes 2 No			utpatient 3 1 DOA		Home 5 Thes ider	nce 6 X Other (Sp	ecify) Residence
n C	After t	ü	27. Manyer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)			njury at Vork?	28d. Describe hov	w injury occurred	
Vision Attending	death. c tor : / y the fi	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he	At home fr		□Yes 2□No	29f Location (Str	eet and Number or F	Rumi Route Number
Oivi or A	after death Director : d in by the f	Certification:	4 Homicide determine	building, etc.	(Specify)	arm, street, factory, offic	e	City or Town,	State)	iurai rioute rumboi,
Hospital	within 24 hours after To the Funeral Dir completely filled in	Medical C		Physician: To the best o aminer: On the basis of and manner stat	examination a					
o the	fo the	Me	29b. Signature and title of certifier	7			ense number		d. Date signed (Mor	
	2,.0		19-6//		_		1530,	95 C	Grosez a	26,7009
			30. Name and addre of person wh	no completed cause of de	ath (Item 23a)	(Type, Print)	16 5,0	122, m	0,	- '
4)	1		30. Name and address of person when the state of the stat	non CT	#210	Timonia	in, MA	Zywans	20093	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	are				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 34880 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear 13:35 PM WILLIAM PARIETTA OCT 26 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimor 1+ques HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 960 MARCH 7,1913 VIRGINIA 218-48-3854 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 XYes 2 □ No BALTIMORE MARYLAND 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 828 AUGUSTA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: BLACK 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NAVAL SEAMSTRESS 10TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) OLETHIA SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ERE N. AUGUSTA AVE, BALTIMORE, MD 21229 WILLIAMS (SON) KUNALD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 10/30/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SOSEPH H. BROWN JR. FUNERAL MICHE
RIYO N. FULTON AVE., BALTIMER, MID 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final davis pnellmonia disease or condition resulting in death) Due to (or as a consequence of): tailure acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑No 1 ☐Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner be executed 68760, Division of Vital Records, P.O. or Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

<u>ک</u>

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine Trust be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit funeral director, this After t ours after death. within 24 hours a To the Funeral D Hospital

Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 25. Was case referred to medical examiner? æ 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

29c, License number

58571

Avenue

29d. Date signed (Month, Day, Year)

Oct 26, 2009

Baltimore maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Tao 960 Caton Unn

32. Penistrar's Signature

Day, Year)

29b. Signature and title of certifier

31. Date filed (Month)

MO

State Registrar State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

34881

Physici /Medic Examin

Funeral Director

iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be recallised at

Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be executed by the attending physician and real Director: After this certificate has been signed by the attending physician and rilled in by the funeral director, page 2 should be detached for use as the burial-transit and property and pr	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin once.
ecuted nd ransit		Physician
ecuted nd ransit		/Medical Examiner
spit nours nera	Division of Vital Records, P.O. Box 68760,	sit sed
		Sta

	1 - State Registrar	waryiaria / L	Certifica	te of Deatl	h	Reg	No. 2009	34881			
n al	1. Decedent's Name (First, Middle, Last) Percy Adam Walker, J	r.				2. Date of Death Month OCTOBER	Day Year 24, 2009	3. Time of Death			
er	4a. Facility Name (If not institution, give street and numi Union Memorial Hospi	tal		, Town, or Location Balti	more		4c. County of Death	A			
	5. Social Security Number 216-84-4050 6. Sex XXM 2 F 7	Age (In yrs. last bir 45	Yrs. If Under		Min.	B. Date of Birth (Month, Day, Young) June 13	9. Birth Cou 1964 Ma	place (State or Foreign intry) ryland			
tor	10a. State 10b. County N/A	10c. City, Town		timore				10d. Inside City Limits XX es 2 □ No			
al Direc	10e. Street and Number 3311 Mary Avenue		10f. Zi	p Code 21206	<u>. </u>	10g	Citizen of What Cou	intry?			
Completed by Funeral Director	11. Marital Status 1 Married Forces? 1 Married Status 1 Married										
mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Laborer Paint Industry										
To Be Co	17. Father's Name (First, Middle, Last) Percy A. Walker, Sr.		na	18. Mot		(First, Middle, Mai	den Surname)	naustry			
	19a. Informent's Name/Relationship (Type. Print) Bertha Lee Green/ Mot	her 45	09 Gre	en Rose	Lane	Balti	ity or Town, State, Zi more, MD	21213			
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)		f Disposition (Na ry, crematory or wn Cem	etery	10/29	9/09 В	altimore	, MD			
	21. Signature of Funeral Service Licensee		4210	Belair	Road	Baltim	ore, MD				
	Due to (or	res a consequence of	ASCUL				,	Approximate Interval Between Onset and Death			
Medical Certification: To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Ceuse (Disease or injury that initiated events c.	as a consequence of									
ysician/Med	in the past 12 months?	ome of pregnancy th 2 ☐ Fetal death nt at time of death vn	3 ☐ Ectopic 5 ☐ Other (s				23d. Date of deliv	very Day Year			
ed by P	Part II. Other significent conditions contributing to dea	th but not resulting in	n the underlying	cause given in Par	t I.		co use contribute to	the cause of death?			
Complet						24a. Was an autopsy performer	prior to co	opsy findings available ompletion of cause of 2 No			
Be	25. Was case referred to medical examiner?				ce of Death	(Check only one)					
은	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Ing 27. Manger of Death 28a. Date of		tpatient 3 D			e 5 Residence	e 6 Other (Specinium occurred	ify)			
cation	1 ☑ Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation		njury M	28c. Injury at Work? 1 □ Yes 2 [od. Describe now	injury occurred				
Certifi	determined 286. Place 0	Injury - At home, fa , etc. <i>(Specify)</i>	rm, street, factor	ry, office	28	3f. Location (Stree City or Town, S	at and Number or Rui State)	ral Route Number,			
edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the base and manner and manner.	is of examination an	e, death occurred nd/or investigatio	d at the time, date n, in my opinion, d	and place, a	nd due to the cau d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)			
ž	29b. Signature and title of certifier			c. License numbe			Date signed (Month				
		A . D.		47243			NBER 2				
	30. Name and address of person who completed cause HEE - JOO N. PAN	MP	, UNION	1 MEMUI	RIALL	10SPITAL	, BALTIMO	ORE, MP			
e Ir	31. Date filed (Mont) 0 CT Y3') 2009 32. R	www f.	back								

Morratel WILSON JR.,

			State Registrar		I / Department of F Certificate of I	Death	Re	g. No. 2009	34882
Ph	ysicia	ın	1. Decedent's Name (First, Middle, La Wilson	st)	Worrell	.Tr	Date of Death Month	Day Year	3. Time of Death
	Medic camine		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or	Location of Death	KTIN	4c. County of Deat	
			Sinsi Hospital of	Boltimore	B21+	imore GT	5		
	neral ector		5. Social Security Number 6. S 216–36–8135	ex 7. Age (<i>In yrs. la</i> . 70	st birthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, 8 24	9. Birt Co 39	thplace (State or Foreign buntry) MD
ъ			Usual Residence of Decedent				0 24	39	
larylar	ad at	'n	10a. State 10b. County		Town or Location				10d. Inside City Limits 1√□Yes 2□No
the M	notifi	Director	MD NA 10e. Street and Number	ва	1timore 10f. Zip Code		10	g. Citizen of What Co	23
th with	ast be		3805 Fordleigh	Road Apt B	2.1	L215		U.S.A	A •
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show	event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1	. 13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑No	ispanic Origin? (Specit un, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White	e, etc.
5-0036 72 hours aft natural", or	al Exa	ed by	3 Widowed 4 Divorced	Year or Dates:	16a. Decedent's Usual Occup		1	Specify: If 6b. Kind of Business/	3lack
ים זייי יי זייי זייי ייי	Medic	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	college (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of working		ob. Kind of Business/	mastry
sd with ygiene	4	Com	llth grade	na	Truck Dr			Master Au	ıtos
and d be filk ental H ced oth		Be	17. Father's Name (First, Middle, Last Wilson Worrell			18. Mother's Name (F			
Ly hould be mark	ımatlo	은	19a. Informant's Name/Relationship		19b. Mailing Address (Street	and Number or Rural F	Route Number,	City or Town, State, 2	Zip Code)
M 2 Ind 2 In	or other traumatic		Shirlene Worre	.1-Daughter	3805 Fordle	eigh Road	Apt I	B, Baltin	more, Md 21215
S - S - S - S - S - S - S - S - S - S -	ry or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specie		ace of Disposition (Name of metery, crematory or other place outus Memoria			coc. Location - City or	
baltimor permit. Pages Department of Important: If its	any inju once,		21. Sign ture of Funeral Service Lice		22. Name and Addre March F/1 4300 Waba	ss of Facility	halti	more, Md	21215
			23a. Paryl. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	Do not enter the mode of dyir	ig, such as cardiac or r			Approximate Interval Between
Physic			Immediate Cause (Final disease or condition resulting in death)	a Anoxic a	acylisty try ence of): Arting Dires				Onset and Death
/Med Exam			resulting in death)	Due to (or as a conseque	ence of):				7.
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):	n	.,		Tyrs.
scuted	transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C					
oo fou, ificate be executed g physician and	the burial-transit	Ж	resulting in death) Last	Due to (or as a conseque	ence of):				
		79		d					
_ m -=	as the	Medical	IS SEMALE.	d					, , , , , , , , , , , , , , , , , , ,
O. BOX he death ce	for use as	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	23c. If yes, outcome of pregnan 1	death 3 Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
hat the dead by the	for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of the second seco	death 3 ☐ Ectopic pregnanceath 5 ☐ Other (specify)		23e. Did tob		Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jadine **Physician** 26,200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number (In yrs. last birthday) **Funeral** Year) 1 □ M 2 1 F Months Days Hours Min 217-56-591 Usual Residence of Decedent Yrs. Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. items 23a or 28a-f show 1 XYes 2 □ No Completed by Funeral Director more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. ,DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nTe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) (mother) 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 130/2009 22. Name and Address of Facility JOSEPH L. RUSS 2227 W. North uneral Service Licensee Ave. Barto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breac **Physician** Me O montu /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are utilized to the conditions of the capture of the cap Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ (No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **H**No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 □Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 200° 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ucusles. 31. Date filed (Month, Day, Year

Pada

ethin

5601

32. Registrar's Signature

Loch Raven Blod

Baltimore, MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 3 **Physician** 04:11 AM OLTOBER 2009 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** moria 9. Birthplace (State or Foreign Social Security Number **Funeral** -28-996 Months Days Hours Min 1 M 2□ F **Director** Irainia Usual Residence of Decedent 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Mackel Evening must be notified at 10b. County 10c. City, Town or Location 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭Yes 2 ☐ No It/Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify: 3 Widowed 4 Divorced ac Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) On 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)-20b. Place of Disposition (Naticemetery, crematory or community) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Wings Mi 21. Signature of Funeral Service/License Home, North 23a. Part/ Enter the disease shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke Hemorrhance **Physician** 4 hours /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unknown Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Unknown Afnal fibrillation and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performe 2 **1**No 2 🗆 No 1 🖺 Yes To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 AMatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D 32. Registrar's Signature

KHATKAR

A72438946

UNION MENOPIAL HOSPITAL, BALTIMORE, MD, 2/2/8

29d. Date signed (Month, Day, Year) OC TOBER, 23, 2009

09-	0836	33

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

Donald Douglass \	1.	For State	State of Maryland /		nent of Heal cate of Deat			eg. No. 20	009 348 8
Physician	/ 1	e qistrar . Decedent's Name (First, Mi			I.I		2. Date of Dea Month October 2	ath	3. Time of Death 1010 hrs
Medical Examine		Donald	Douglass ution, give street and number)		Wenge	Town, or Location		28, 2009 4c. County of De	
h . A	_	Baltimore MD VAM				more			
Funeral Director		5. Social Security Number 236–68–3986	6. Sex 7. Ag	e (In yrs. last bi	irthday) If Und Mont		a Min	rth(MM/DD/YYYY) 9. Fo 28, 1945	Birthplace (State or West Country) Virginia
9	_	Jsual Residence of Deceden	t						10d. Inside City Limits
15200	- 1	10a. State 10b. Cour	·	10c. City, Tow	n or Location ddle Rive	r			1 Yes 2 X No
Tyland tronce	ᄓ	Maryland Ba	altimore			p Code		10g. Citizen of What 0	Country?
the Ma a or 28 tiffed 3	<u></u>	533 Holly Hur	nt Road			21220		USA	
h with	Funeral	11. Marital Status 1 Never Married 2	12. Was Decedent	Ever in U.S.	13. Was Deced	tent of Hispanic Or cify Cuban, Mexica	igin? (Specify Yes or N n, Puerto Rican, etc.)	14. Race - A White, et	merican Indian, Black, tc.
er deat			Divorced If Yes, Give Year	No	1 Yes	2 X No specify	<i>/</i> :	Specify: W	hite
ours afi atural'	وا - اغ		Specify only highest grade cor	mpleted) 16	a. Decedent's Usua during most of w	al Occupation (Give	e kind of work done T use retired)	16b. Kind of Busine	
16 n 72 h nan "m ical E)	Completed	Elementary/Secondary (0-	12) College (1-4 or	5+)	Owner	3		Chas Lawn Mow	er Service
-003 d withi giene. ther th	탉	12 years 17. Father's Name (First, Mic	ddle, Last)		Owner	18.Mothe	er's Name (First, Middle		
215 215 be file mtal Hy rked o	8	Earl Wayne W					nel Puffenb umber or Rural Route N		State Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	岭	19a. Informant's Name/Relat			19b. Mailing Addre	ss (Street and NU lv Hunt F	Road, Middl	e River, M	1D. 21220
S, M and 2 Health item 2'	ı	Betty Wenger 20a. Method of Disposition		20b. Plac	e of Disposition (N	lame of cemetery.	Date	20c. Location - Ci	ty or Town, State
TOFC Pages 1 ent of 1 nt: If		1 X Burial 2 Crema 4 Donation 5 Othe	ation 3 Removal from S	Holly	natory or other place Hill Memor	rial Garden	3, 2009	Middle F	River, MD.
Saltir rmit. I epartm nporta jury or	1	21. Signature of Funeral Ser	vice Licensee	20/	22. Name ar Conn	nd Address of Facil	eral Home o Point Road	f Dundalk,	P.A.
	-	23a. art I. Enter the di	e, or complications that cause	d the death. Do	not enter the mod	SOLIERS le of dying, such as	cardiac or respiratory a	arrest, shock, or heart	Approximate Interval Between Onset and
Physician /Madical	-		ease a. Cardiome						
xaminer		or condition resulting in dea	th) Due to (or as a cons	sequence of):					
	<u>ه</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con:	sequence of):					
	Examine	cause. Enter Underlying Ca (Disease or injury that initiat	ted C.	sequence of):					
auted nd nd ransit	Ä	events resulting in death) L	d	,					
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876(ifficate ng phys	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome tin the Live birth	ome of pregnar	ncy 2 Fetal dea		ppic pregnancy	Month Month	Day Year
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n of Vi iing Physi After this	: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of li (Month, Da	njury 2	8b. Time of Injury	28c. Injury at W		be how injury occurre	d
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,		4 Homicide 29a. Certifier 1 Certifyi (Check only	ing Physician: To the best of al Examiner:On the basis of e	my knowledge	, death occurred a	t the time, date and	d place, and due to the o	cause(s) and manner a	as stated. ue to the cause(s)
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	2	~ ~				O.C.M.E.		October 29	, 2009
W./			person who completed cause of						
- V V		Donna M. Vincent				nn Street, Balt	imore, MD 21201		
St Regist	tate trai		3 0 2009 32. Regis	strar's Signature	1. bar	<u></u>			
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The common of th		_		_	_	Jarren				Date of Death Month	Day Y	ear	3. Time of Death 6:15 P. M	
Second Security Number Second Sec								4b. City, Town, or	Location of Death	october				
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100. State 100. County 1				218 64 0364			* '			8. Date of Birth (Month, Day, 03/07/	(ear) 1955	_ Çoun	try)	
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Physician Medical Examiner Ph	lary	2 shou and h is ma			rpe. Print)		1				City or Town, Sta	ate, Zip	Code)	
Physician Medical Examiner Ph	≥ ນົ	1 and Health em 27 ther tr			niece	Jook Di								
Physician Medical Examiner Ph	2	ages ent of l t: If ite y or o'		1 🖁 Burial 2 🗒 Cremation 3 🗆 F	Removal from Sta	ite C6	emetery, crem	atory`or other plac	e)					
Physician Medical Examiner Ph		permit. F Departm Importar any Injur ance.			2:00	ced	22.	Name and Addres	ss of Facility Go	nce Funer	ral Serv	ice	, P.A.	
Physician Medical Cause (Final disease or condition scaling in death) Sequentials its conditions as consequence of): Due to (or as a consequ				23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	cations that cause on each	sed the death						lary.	land 21225 Approximate Interval Between	
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State Stat	600	uires mar signed b id be deta	þ	Part II. Other significant conditions con	tributing to death	n but not resul	ting in the un	derlying cause give	n in Part I.					
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day) 32. Registrate Signature 33. Registrate Signature 34. Date filed (Month Day) 35. Registrate Signature 36. State	- 3	D e e	tion	1 → Natural 5 ☐ Pending			lnjury	Work	?	28d. Describe how	injury occurred			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day) 32. Registrate Signature 33. Registrate Signature 34. Date filed (Month Day) 35. Registrate Signature 36. State		a or Atter after dea Director d in by the	ertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of building,	Injury - At hor etc. (Specify,	ne, farm, stre			28f. Location (Stre City or Town, S	et and Number of State)	or Rural	Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. 5 cm 31. Date flee Month Page 32. Registral Signal reports (Item 23a) (Type, Print) 32. Registral Signal reports (Item 23a) (Type, Print)	11.00	e nospin 124 hours e Funera letely fille		Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									ated. the cause(s)	
State 31. Date filed (Mark Page 1) 32. Registral Signal years Signal y		withir To th comp	Me	29b. Signature and little of certifier	MI	2/		29c. License	number 3/75	290	Date signed (M	Aonth, E	Day, Year)	
State 31. Date filed (March Page 10) 32. Registral Signal years	7	2		30. Name and address of person who co	mpleted cause o	f death (Item	23a) (Type, P	rint)	10.	- (1)	Sharing	M	71011	
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State

Registrar

31. Date filed (Month, Day, Year)

001 30 200

Laron Locke MD.

32. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

		or tate egistrar			St	ate of I	Maryla	nd / [tment e ificate			nd M	lental F	łygien Reg. N	2 13 1	9	3488
Physiciar /Medica Examine	n ai	edent's Nam	I	DWARD		W.	WEI	BE	SR.	1b. City, To	wn, or Loc	ation of	Death	2. Date of Month	BE	28 c. County of	2001	3. Time of Death
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S 8 0 1	11. Ma	rital Status Never Mari Widowed	ried 2] Married	12. W A 1	as Decedermed Force □Yes 2 Yes, Give ear or Date	es y No	U.S.	1	s Deceden es, specify	t of Hispar Cuban, M		in? (Spe Puerto	ecify Yes or Rican, etc.)	No-	14. Race -		
d within 72 ho giene. er than "natu , tre Medicel	Completed	(Spe nentary/Seco 12	cify only	cedent's E highest gr 0-12)	ade com	ollege (1-40	or 5+)	16a.	Decede (Give kii life. DC	nt's Usual C nd of work o NOT use i ler	occupation done durin retired)	n g most	of worki	ing	1	Kind of Busin		•
Ald be file Mental Hy arked oth atic event	17. Fa	ther's Name Gu S	(First, M stav	liddle, Lasi		ibe					18.		's Name Dori	_	_{dle, Maide} erke	en Surname)		
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Dermit Depart Import any In	21. Si	gnature of Fi	uneral Se	ervice Lice	nses	al	ull	K	22.1 320	Name and A Nour	ddress of tain I	Facility Road,	McC Pas	ully-Po adena,	lynial Maryla	k Funera and 211	al Hom 22	e P.A.
or or or cate be cate be only sicial the burner of the bur	Seque if any, cause that in resulti	diate Cause se or condition in death) antially list colleading to in Enter Unde (Disease or itiated eventing in death)	onditions, mmediate erlying r injury ts	{	a. <u>N</u> b. <u>Y</u> c	NE	as a conse	equence o	of): Cof):	Lu	re ing	<u>ځ</u> د	A	1CE				nset and Deat
the death certification by the attending posterior of the control	IF FEM 23b. V ir 1	MALE: Vas deceden the past 12 Yes 2 Unknown	2 months □No		1 4	yes, outcor □ Live birt □ Pregnar □ Unknow	h 2□Fe ntattime of	tal death		ctopic preg other (speci					-	23d. Date of Month		
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ian: The law requir trifficate has been sitor, page 2 should I	25. Wa	as case refer	rred to m	edical							26.	Place	of Death	24a. W au pe 1 □ Ye	rformed?	'l dea	ath?	y findings avail letion of cause
lor Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as entitication. To Be Completed by Divisional Machinery	examiner? 1 Yes 2 No 1 Yes 2 No 27. Manns of Death 1 Aurain 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicid								loute Number,									
To the Hospital or Attent Within 24 hours after death To the Funeral Director: completely filled in by the Madical Certificat		ertifler Check only one)	1 Ce 2 Me	rtifying Pl dical Exa	hysician miner: 0	ı: To the be	est of my kr s of examin	nowledge	, death o	ccurred at	the time, d	late and	i place,	and due to	the cause	(s) and mani nd place, an	ner as stat d due to th	ed. le cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		rtificate of		ina ivientai H	Reg. No	2009	34889		
ı	Physicia		1. Decedent's Name (First, Middle, Last) Peter Michael	'agjian				2. Date of I Month OC tob	Da	7 2009	3. Time of Death 12:01 PM		
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of			. County of Dea			
	Funeral Director		010-32-7202	7. Age (<i>In y</i> i	rs. last birthday) Yrs.	Baltin If Under 1 Year Months Days			Birth Day, Year)	9. Bir Co 944 Mas	thplace (State or Foreign suntry) Sachusetts		
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ty, Town or Location 10d. Inside City L							
	Maryla-f	ctor	Maryland		Baltimo	ore City			1 ☑ Yes 2 [
	vith the	Director	10e. Street and Number			10f. Zip Code	001		10g. Citizen of What Country?				
	ns 23	Funeral	920 Fell Street	12. Was Decedent Ever in	U.S. 13. 1		.231 Hispanic Orig	nin? (Specify Yes or I	No-	14. Race - Ame			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by	1 ☐ Never Married 2 🛛 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify Cub 1 □ Yes 2 🕱 No		gin? (Specify Yes or I Puerto Rican, etc.)		Black, White	_{e, etc.} Nhite		
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212	d withir giene. sr than	Completed	Elementary/Secondary (0-12)	Coilege (1-4or 5+) 5+	0wr		:u)		F	Restaura	int		
Baltimore, Maryland	ild be filed fental Hy ked othe lic event,	To Be C	17. Father's Name (First, Middle, Last) Sarkis Yagjian					rs Name <i>(First, Mido</i> Zabeth Mo	lle, Maider onjia	ŕ			
Aary	2 shou and N is mai	_	19a. Informant's Name/Relationship (Ty		I			r or Rural Route Nur			, ,		
ē,	f Health tem 27 other t		Lorraine B. Yagjia			w. Cheso sition (Name of natory or other pla	·	Avenue, T		ocation - City or			
<u>m</u>	Pages nent of ant: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren illtop S	patory or other pla Service (corp. 1	1/2/2009	Tov	wson, Ma	ryland		
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service License	Pudu	22			Ruck Toward, Towson			Home, Inc. 21204		
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de e cause on each line.	ath. Do not ent	er the mode of dy	ing, such as c	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death		
Bane .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Co Ronar Due to (or as a cons	_	rtery	dia	ease			15yrs		
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	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Dis to (or as a cons	equence of):						J		
o,	tificate be executed g physician and as the burial-transit		that initiated events cresulting in death) Last	Due to (or as a conse	equence of):								
68760,	physici the bu	edical	d	·									
	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	tal death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	livery Day Year		
J.	uires that the de signed by the d be detached f		Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying cause gi	ven in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?		
ords	w requires been sig should be	ted by						1	Yes 2	□ No 3□ P	robably 4 🗆 Unknown		
		Completed						24a. Wa au pe 1 ∐Yes	topsy rformed?	prior to death?	utopsy findings available completion of cause of		
Vital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:		Oti		of Death (Check only					
ر 10	ding Phys h. After this funeral dii	n: To	27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	I SLI DOM	4 🗆 Nui:	sing Home 5 Re 28d. Describ			cify)		
Division of	or Attending Physician: ther death. Director: After this certific in by the funeral director,	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 □	Yes 2□N						
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	e Hosp 124 ho e Fune letely f	edical	29a. Certifier 1 ✓ Certifying Phys (Check only one) 2 ☐ Medical Examir	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or in	n occurred at the t vestigation, in my	ime, date and opinion, death	d place, and due to to h occurred at the tim	ne cause(s e, date an	s) and manner a d place, and due	s stated. e to the cause(s)		
	To th withir To th comp	Me	29b. Signature and the of certifier	14	^	29c. Licens		>	29d. Da	ate signed (Mont	h, Day, Year)		
	,	-	Jangtell	mon my	J		25.	5	/0	128/0	9		
	6 V		30. Name and address of person who con LARRY A.W.I		em 23a) (Type,	mpbell	Blvd	. Snite 12	5, 30	Stronge	mD 21236		
	Stat Registra	-	31. Date filed (Month, Day, Year)	32. Registrar's Sig		Bertis			-				

DHMH 17 Rev 1/2001

			. 101	partment of Health and Mental Hertificate of Death	lygiene Reg. No. 2009	34890
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Phillip Barnes Bailey	2. Date of Month OCT.	Death Day 2009	3. Time of Death 6:15 A M
	Examir		4a. Facility Name (If not institution, give street and number) 6425 Baileys Store Road	4b. City, Town, or Location of Death Federalsburg	4c. County of Death	
٤,	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219-34-4017 75 Yrs.	Months Days Hours Min. (Month,	Day, Year) Co.	hplace <i>(St</i> ate or Foreign untry) ryland
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	ederalsburg	10g. Citizen of What Co	
036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	6425 Baileys Store Road 11. Marital Status 1 □ Never Married 2 Nameried 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	21632 3. Was Decedent of Hispanic Origin? (Specity Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□Yes ★□No Specify:		rican Indian,
Baltimore, Maryland 21215-0036	ed within 72 ho giene. er than "natur er the Medical I	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) r of Trucking Company	Grain/Fe	•
ryland	should be filed and Mental Hygis marked other umaric event, ti	To Be (17. Father's Name (<i>First, Middle, Last</i>) Lehman Bailey 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma	18. Mother's Name (First, Midde Mary Bradle illing Address (Street and Number or Rural Route Route Number or Rural Route	еу	7in Code)
ore, Ma	es 1 and 2 s of Health an fitem 27 is i rother trau		Catherine Bailey/Spouse 642 20a. Method of Disposition 20b. Place of Dis	25 Baileys Store Rd.	Federalsb	ourg, MD Town, State
Baltimo	pe mit. Pages De artment of i Im ortant: If it any injury or o		21. Signature of Funeral Service Licensee	Cemetery 10/10/09 22. Name and Address of Facility Framptom 216 N. Main St., Federal	Vienna, M	e, P.A.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expected the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	1 1111		Approximate Interval Between Onset and Death >10425 >10425
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transiting.	Physician/Medical E	d	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of del Month	ivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	,····g g.···	id tobacco use contribute to	the cause of death?
Vital Records,		Completed		pe 1□ Ye	utopsy prior to death? s 2 → HO 1 □ Yes	topsy findings available completion of cause of
	Physicial this certiral directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		esidence 6 Other (Spender has been been been been been been been bee	cify)
Division or	To the Hospital or Attending Physician: within 24 hours after dearh. To the Funeral Director After this certifical completely filled in by the funeral director,	Certification:	1	y Work? M 1	n (Street and Number or Ru Town, State)	ural Route Number,
	e Hospital o	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
1	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	29c. License number D0053236	29d. Date signed (Mont	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Secretary 5.22 Edition (Secretary 5.22 Edition)

31. Date filed (Month, Day, Year)

OCT 0.7 2009

32 Registrar's Signature 522 Ithuris Aus EASDN MD
32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

09-08011 Adam Palmer Burch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 34891

		- For State		Ce	rtificate of	Death					eg. No.		
Physicia	n/	I. Decedent's Name (First, Middl	e,Last)							Date of Deat Month	Day	Year	3. Time of Death 1345 hrs
ledical Examir		Adam Palmer	Burch							October 1		aty of Dea	
	4	4a. Facility Name (if not institution 21909 Whites Neck R		mber)		4b. City, Town, or Location of Death Bushwood					4c. County of Death St. Mary's		
E	٠,	5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1		If Under 2	24Hrs.	8. Date of Bir	th(MM/DD/Y	YYY) 9. B	irthplace (State or
Funeral Director		220-29-7781	1 X M 2 F		18 Yrs	Months	Days	Hours	Min.	11/09	/1990	Fore	country) Mary Land
	⊢	Usual Residence of Decedent	IAM Z		10 110								
any	<u> </u>	10a. State 10b. County		10c. City	y, Town or Locat	tion							10d. Inside City Limits
<u> </u>		Maryland	St. Mary's		Avent	1e							1 Yes 2 X No
Aaryland 28a-f show 1 at once,	Director	10e. Street and Number				10f. Zip Code					10g. Citizen o	f What Co	ountry?
the Na or 3		38290 Wilmer Pa	lmer Road			20609						USA	
ms 23	Funeral	11. Marital Status		edent Ever in U	U.S. 13. Wa	is Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.)					0- 14. F	Race - Ame Vhite, etc.	erican Indian, Black,
r deatl	뒤	1 Never Married 2 X M	1 Yes	2 X No	1,-	Yes 2 X No specify:					Spec	ifv rn.	
s afte	2	3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates:		16a. Decede				nd of wo	ork done	16b. Kind	7711.	ite s/Industry
2 hour	Completed	Elementary/Secondary (0-12)			during n	nost of worki	ng life. D	O NOT us	se retire	ed)			
336 thin 7 ee.	힐	12				Attend						s Stat	ion
5-0(ed wir fygier other	3	17. Father's Name (First, Middle	e, Last)				18	.Mother's	Name (First, Middle,	Maiden Surn	ame)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	æ	Ernest Bento							enda	Cathe		Morris	ate, Zip Code)
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medir I Examiner must be notified at once	2	19a. Informant's Name/Relation									MD 2060		ate, Zip Odde)
MD and 2 she em 27 is raumat	ŀ	Ernest Benton 20a. Method of Disposition	Burch / Fath		D. Place of Dispo				au,	Date .			or Town, State
Ore		1 X Burial 2 Crematic	on 3 Removal fr	om State	crematory or o		0 . 1 .	- 1		ber 20,	Leon	ardto.	n, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Donation 5 Other S 21. Segnature of Funeral Service	Specify:	Cr	narles Mer					2009			ral Home, P.A.
Bal permi Depar Impo injur	- 1	21. Arghature of Funeral Service	Tardin	100]	масс Р.О.	Box 270	Gardinei). Leona	rtown	, MD 20650
Physician	\dashv	23a. Part I. Enter the disease,	or complications that complications	caused the dea	th. Do not enter	the mode of	dying, s	uch as ca	rdiac or	respiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and
/M. dical		failure. List only one caus Immediate Cause (Final diseas	أحا مامندا مامند	iuries									Death
aminer		or condition resulting in death)	Due to (or as		e of):								
		Sequentially list conditions,	b		-0								
	Examiner	if any, leading to immediate cause. Enter Underlying Caus		a consequence	e OI).								
T :	xan	(Disease or injury mat initiated events resulting in death) Last	Due to (or as	a consequence	e of):								
recuted and transit			d										
760, cate be exe physician a	Medical	UNPENDED	AMENDED								23d. D	ate of deli	ivery
Box 68760, edeath certificate be the attending physical for use as the bured for use as the bure.	N/u	IF FEMALE: 23b. Was decedent pregnant in		, outcome of pr birth		Fetal death	3	Ectopic	pregna	incy		onth	Day Year
Sox 687 leath certifing e attending	sician/	past 12 months?	lateration Tight	nant at time of	de etc	Other (Spec	ify)						
Bo he dea the a	Phys	Part II. Other significant cond	9 DIKI	nown	ot resulting in the	e underlying	cause di	ven in Pa	rt I.	23e. Dio	tobacco use	contribut	e to the cause of death?
P.O. es that the gned by	ģ	Part II. Other significant cond	Attoris Contributing	to death but no	or reading un	o unocnymig	J			1 🗆 🕻	Yes 2 ✔ N	o 3	Probably 4 Unknown
IS, Fraguires again sign	Completed									24a. W		24b. Wer	re autopsy findings available
cords, law requir has been s	월	<u> </u>								ре	topsy rformed?	deat	th?
tal Recian: The certificate ector, page	5						26 Place	of Death	(Check	only one)	s 2 No		Yes 2 No
Division of Vital Records, pital or Attending Physician: The law requiremental entered in the taw tender that Director. After this certificate has been siftled in by the funeral director, page 2 should be	Be	25. Was case referred to medi examiner?	Hospital:	Inpatient 2	ER/Outpatie			Other'4	-	ng Home 5	Residenc	e 6 🗸 (Other: Scene
of Vi ing Physi After this uneral dir	<u>٩</u>	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time o	of Injury 2	28c. Injur	y at Work	(?	28d. Descri	be how injury	occurred	vehicle into tree
on c arth. rr: Af	턀		/101119 Oct 15	th, Day, Year) D:	FOUND: 1330 hrs		1 Y	'es 2 🗸	No	Driver pu	rposeruny	ulove v	eniole into tree
IVISIOI or Attene after death Director:	fica				At home, farm, s	treet, factory	, office b	uilding, et	tc.	or Tow	n. State)		or Rural Route Number, City
Div pital o ours af eral D	Certification:	4 Homicide	etermined (Specific) Local St						21909 Whi	ites Neck R		shwood, MD
Division of Vital Records, P.O. Box 68760, within 24 horsital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only 1 Certifying	Physician: To the b xaminer: On the basi	est of my know	vledge, death oc	curred at the	time, da	ite and pla	ace, and	d due to the c	ause(s) and place	manner as	s stated. to the cause(s)
To the Hos within 24 h To the Fun	Medical		and manner	s or examination	on and/or investi			e number		at allo allio, d			(Month, Day, Year)
	Σ	29b. Signature and title of cert	titier			290	O.C.I					per 16, 2	
200		N-~	L 1m				0.0.1	¥1. —			0.0.0		
22		30. Name and address of pers Donna M. Vincenti,		use of death (: Medical E:	_{item 23a)} xaminer 1	11 Penn	Street.	Baltim	ore, N	/ID 21201			
	tate		_	Registrar's Sig	inature .								
Regi		3111 7 (2009	me	B. 191	Wed							
DHMH 17 Rev 1	2001		0.00		ORIGII	NAL							

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hygiene. The portment of Health and Mental Hygiene. The protest is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, the Modical Eventine count be notified at once.	To Be Completed by Funeral Director	10a. State Maryland 10e. Street and Number 22501 Ivers 11. Marital Status 1 Never Married 2 Specify only [Specify only Elementary/Secondary (12 17. Father's Name (First, I) Jack Pau 19a. Informant's Name/Re Jaclynn A. 20a. Method of Disposition 12 Burial 2 Cren 4 Donation 5 0 21. Signature Funeral S
Physician /Medical Examiner	al Examiner	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1
To the P within 2- To the F complete	Medi	29b. Signature and title of

Funeral Director

	1 - State Registrar	,	Certificate of	Death	В	ea. No.	2009	3489			
	Decedent's Name (First, Middle, Last)				2. Date of Deat	h		3. Time of Death			
in al	Robert Paul Bell				October	15^{pay}	2009	2002			
	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Deal	th		County of Death				
	22501 Iverson Street # 6		Calif				St. Mary				
	573-27-7362 12⊠ M 2□ F	e (In yrs. last birth	rs. If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^{Year)} 959		lace (State or Fore try) fornia			
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li											
	Maryland St. Mary's	Ca	lifornia					1∐Yes 2∰			
i	10e. Street and Number		10f. Zip Code		1	0g. Citiz	en of What Coun	try?			
	22501 Iverson Street # 6				U S A						
	11. Marital Status 12. Was Decedent Armed Forces?		 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1.	 Race - Americ Black, White, e 				
	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	No	1 □ Yes 2 ½ No	Specify:		Specify: White					
ĺ	15. Decedent's Education (Specify only highest grade completed)	1 (Decedent's Usual Occu Give kind of work done	durina most of wo		16b. Kin	d of Business/Inc	dustry			
ľ	Elementary/Secondary (0-12) College (1-4or	5+)	life. DO NOT use retire	nd) -							
ŀ	12 17. Father's Name (First, Middle, Last)	Ai	ircraft Mec	1	me (First, Middle, I		Boeing				
	Jack Paul Bell			Cathe		sepl		anphere			
ŀ	19a. Informant's Name/Relationship (Type. Print)	19h. l	Mailing Address (Street								
1	Jaclynn A. Bell/Daughter		66 Country								
1	20a. Method of Disposition		Disposition (Name of crematory or other pla				ation - City or To				
	1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other pla ton Nationa		9/2009	Arli	ngton, V	'irginia			
ŀ	21. Signature Funeral Service License			1			-	_			
21. Signature Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650											
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition	the death. Do no	ot enter the mode of dy	ing, such as cardia	c or respiratory arr	est,	P	Approximate Interval Between Onset and Death			
	06	a consequence of	SUP SI	opn A	onea			2006			
	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury) LAMEN CAMEN										
Sequentially ist contactions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Lidhey Cihier Lidhey Cihier											
-	IF FEMALE:										
	23b. Was decedent pregnant in the past 12 months? 1		2:	3d. Date of delive Month	ery Day Year						
Ì	Part II. Other significant conditions contributing to death b	bacco us	cco use contribute to the cause of death?								
•		1 □ Ye	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown								
			24a. Was a	n I	24b. Were auto	psy findings availal					
1					autops	opsy prior to completion of conformed? death?		mpletion of cause of			
ŀ	25. Was case referred to medical			OC Place of Do		2 No	1 ☐ Yes	2 LINo			
	examiner?	ent 2 ER/Outp	octions 3 DOA Oti	nor:	ath <i>(Check only on</i> Home 5 Reside		Other (Consider				
ì	27. Manner of Death 1 K Natural 5 □ Pending (Month, De	ıry 28b. Tir	Batterit & El Bert	iry at	28d. Describe ho			у)			
	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)										
29a. Certifier 17S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.											
i h	29b. Signature and title of certifier		29c. License number D33470			29d. Date signed (Month, Day, Year) 10/19/2009					
	18/12		D33				0/19/200	19			
	30. Name and address of person who completed cause of a Rhacker Thaveri M D 2403		ŷpe, Print)	Hollwroe	d. MD 204		0/19/200				
BOIDOM	Bhasker Jhaveri, M.D. 2403		ŷpe, Print)	Hollywoo	d, MD 200		07197200				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Reg. No. 2009 34893 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:44 a M Marie Butler October 0 2009 Joyce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 F Months Days Hours Min. 579-84-8578 50 04/10/1959 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2XNo Maryland St. Mary's Scotland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 49468 Fresh Pond Neck Road 20687 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 Yes 2X No. Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsie Μ. Strosnider Stayton Richard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina M. Butler/Daughter 49468 Fresh Pond Neck Rd., Scotland, MD 20687 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2009 Charles Memorial Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinafield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funera

þ

Completed

Be

2

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or orber traumatic event, in, "Actes Exer.", or other traumatic event, in, "Actes Exer.", and it is not in the second any injury or orber traumatic event, in, "Actes Exer.", and it is not interest.

Saltimore, Maryland 21215-0036

Examine

burial-transi and attending physician for use as the burial signed by the a cate has t

Records, P.O. Box 68760,

of Vital

After this certificate funeral director, page

þ Completed Be Certification: To

Medical

Physician/Medical

Division hours after death. To the Funeral Director: completely filled in by the To the Hospital or 24 The

State Registrar

29c. License number

2 🗌 No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

rson who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

5 ☐ Pending investigation

6 ☐ Could not be

determined

32. Registrar's Signature

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 X Natural

1 Natural 2 Accident

3 Sulcide

29a. Certifier

4 Homicide

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Ma	aryland / E	epartmer <i>Certifica</i>	nt of H	ealth an Death	d Mental F	lygiene Reg. No		34894
, N.)3.	Physici /Medi		1. Decedent's Name (First, Middle, Las Ada Lorelle Brown						2. Date of Month	Death Da		3. Time of Death
	Examir		5. Social Security Number 6. Se	Nurs. 19	e (In yrs. last birt	thday) If Unde	II GV	Location of E	c Groce	40	County of Death Hart 9. Birthp	place (State or Foreign
L.	Director		214-16-9620 1 Usual Residence of Decedent 10a. State 10b. County	□ M 2 💢 F	0.5	Yrs. Months	Days	Hours I	Min. 01/2.	Birth 3/1/99/2		Condition of the City Limits
Maryland 2	vith the Mary or 28a-f sho be notified a	Director	Maryland Harford 10e. Street and Number 1710 F. Landmark	Drive	Forest	10f. Zij	050				tizen of What Cour	1 □Yes 2 No ntry? S O{ America
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Yes, Give Year or Dates:			dent of Hi	spanic Origin n, Mexican, F Specify:	? (Specify Yes or Puerto Rican, etc.)		14. Race - Americ Black, White,	can Indian,
	d within 72 ho giene. er than "natur the Medical I	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			Decedent's Usu (Give kind of wo life. DO NOT u	ork done d ise retired	luring most of)	f working		and of Business/Ind	
	should be filed ind Mental Hygid marked other umatic event, the	To Be (17. Father's Name (First, Middle, Last) Frank Lewis 19a. Informant's Name/Relationship (7)	Type. Print)	19b.	Mailing Addres	s (Street a	Ada P	Name (First, Mid		n Surname) or Town, State, Zip	o Code)
	ges 1 and 2 s t of Health ar If Item 27 is or other trau		Shirley Volkart (N 20a. Method of Disposition 1 W Burial 2 Cremation 3 C	Liece) Removal from State	20b. Place of cemeter	710 F.Lo Disposition (Na	undma me of other plac	rk Dri	ve, Fore	st Hi	LL, MD 2 ocation - City or To	1050
Baltimore,	permit. Pa Departmen Important: any Injury once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Oxford Nak		nd Addres	s of Facility		Funer	al Home,	P.A. , MD 21078
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death									
Records, P.O. Box 68760,	Examiner	iner	Sequentially list conditions, if any facing Lamader cause. Enter Underlying Cause (Disease or injury	of):	1 / Dulman Is a							
	ate be executed hysician and the burial-transit	dical Examiner	Cades (blease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	MANYE Mint	frip	m,	discus	-		
	the death certifica / the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ⊟Ectopic p 5 ⊟ Other (s				_	23d. Date of delive	ery Day Year
	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying of	cause give	n in Part I.			use contribute to t	he cause of death?
	sician: The law r certificate has be rector, page 2 sh	Completed	25. Was case referred to medical						1□ Ye	utopsy erformed? s 2 1 No	prior to co death?	ppsy findings available impletion of cause of
ž Vi	hysicia his cert	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Out	tpatient 3 D	Othe	r _	Death (Check on ng Home 5□R		6 □Other (Specif	fy)
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; p	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	M	Work?					al Route Number		
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	the Hos in 24 ho the Fun pletely i	Medical	29a. Certifier 1 ☐ CertifyIng Phyone) 2 ☐ Medical Examone)	iner: On the basis of and manner sta	examination and	d/or investigation	n, in my o	ne, date and pointion, death	occurred at the tir	ne, date an	and manner as s of place, and due to	o the cause(s)
)	To with To To	Σ	29b. Signature and title of certifier				c. License	humber 1641 L		29d. Da	ate signed (Month,	
			30. Name and address of person who	25 101	is an	c l	106	my) 71	078		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ai s Signature	park	1					

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 736 м Clarence Robert Bryant /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death. Examiner KRAIDNAL 54/136400 1000100 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 XM 2 □ F Months 7-22-1942 MDDirector 216-38-8641 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Invoical Exal, that he routhed at 1 ☐ Yes 2 ☐ No Director MD Worcester Pocomoke City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21851 U.S.A. 506 Young Street 72 hours after death Funeral 12. Was Decedent Ever in U.S.

Armed Forces?

1 Mes 2 No Force
If Yes, Give
Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify: Black ğ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, I'm. I'm. ODGs. <u>Government</u> Worker 12 (Mint) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Inez Bryant 2 Robert Hunter, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 663, Berlin, MD 21811 Antoinne Bryant/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10-19-2009Hurlock, MD VA Cemetery JEU eral Simile Licensee 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final **Physician** 15 Chemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2.☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confine 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regional Medical Center Salisbury ms herles Jr MO 31. Date filed (Month, Day, 32. Registrar's Signature Year) Registrar

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of H	lealth ai D <i>eath</i>	nd Mer	ntal Hygi Re	ene 0 0 9	3489	6
1	;	Decedent's Name (First, Middle, Last)								Date of Death		3. Time of Dea	ath
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al.	Examin		4a. Facility Name (If not institution, g	ive street and nu	umber)		4b. City, Town, or	Location of	Death		4c. County of		
		_97	Caroline Nursi				Denton				Carol		
6	Funeral Director		5. Social Security Number 6 214-32-6266	Sex 1 □ M 2 X F	7. Age (In yrs. 9	last birthday) 5 Yrs.	Months Days Hours Min.			Date of Birth (Month, Day, ct. 16	Year)	9. Birthplace (State or Foreign Country) 1913 Maryland	
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local					10d. Inside City Limits					imite
	shoved at	5										1 □Yes 2 □	
	the N 28a-i notifii	Director	Maryland Queen A	nne		entrev	111e 10f. Zip Code			10	g. Citizen of Wha	at Country?	
	3a or		217 Oak Street				21617	,			U.S.A.	,	
	ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.1	Was Decedent of H f Yes, specify Cuba		in? (Specify	Yes or No-	14. Race -	American Indian,	
36	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, G Year or I	2 X No Sive	- 1	1 Tes, specily Cuba 1 □ Yes 🛣 No		Puerto Rica	an, etc.)	Specify:	White, etc. White	
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nd	be do do do do do do do do do do do do do	Be	17. Father's Name (First, Middle, La	,							laiden Surname)		
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Ma	alth and 2 shalth and 27 is r		19a. Informant's Name/Relationship Phyllis Blades/n				ag Address <i>(Street a</i> ak Street				•		
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lo Io	e = 5		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		n State	-	natory or other plac O Cemeter	1	ct 17	2009	Traencho	ro, Marylan	nd I
Baltimore,	in the party of		21. Signature of Puneral Service Lig	••	010		Name and Address						ra
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	The law requires that the death certificate be executed Washington and with attending physician and bage 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	caused the deat							Approximate Interval Between	en
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			resulting in death)	Due to	o (or as a conseq	juence of:	1	1			(*)	17.	
i i		L.	b. Due to (or as a consequence of):							La Ca			
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Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				1		of Death (C	heck only one	one)		
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			30. Name and address of person wh	io completed cau	use of death (Iter	n 23a) (Type	Print)	110	1	<i></i>	, - 1-	- 01	
			James S	100	59	20/	LANKE	t s	ST	Der	Jton,	14026	29
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	Registr	ar	OCT 161	WH C	som /	B. 190	rest !						

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			For State Registrar	State of	Marylan		artment of rtificate o				giene Reg. No.		34897
	Dhysisi		1. Decedent's Name (First, Middle, La	ist)						2. Date of De Month	<i>a</i> th Day	Year	3. Time of Death
	Physici /Medi		Eliza Berry (ash						Octobe		2009	11:00 PM
	Examir	er	4a. Facility Name (If not institution, given		er)		4b. City, Town	, or Location	of Death		4c. Cou	unty of Death	
-			43 Crescent Link		Ann (Im.	to and the final trade of a last	Nort If Under 1 Yea	h East		O Data of Dia		Cecil	place (Chate or Foreign
	Funeral Director			Sex 7. 1 □ M 2 💢 F	Age (In yrs.	rast birthday) Yrs.	Months Day		Min.	8. Date of Bir (Month, Da	ıy, Yea <i>r)</i>	Cou	place (State or Foreign ntry)
			Usual Residence of Decedent		88				I A	ug. 21	19 21	Vir	ginia
	ylanc	١.	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	a-f s	cto	Maryland Cecil		No	rth Ea	st						1 □Yes 2 No
	iff the	Dire	10e. Street and Number				10f. Zip Code	e			10g. Citizen	of What Cou	ntry?
	ath w	Funeral Director	43 Crescent Link			- T		901				d Stat	
	er de items	n.	11. Marital Status	12. Was Decede	es?	S. 13.	Was Decedent of Yes, specify C	of Hispanic Or uban, Mexica	rigin? (Spe an, Puerto I	cify Yes or No Rican, etc.)	14.	Race - Amer Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 If Yes, Give Year or Date	X.X. ^{VO}		l□Yes 2XXX	lo Specify.	<i>/</i> :		Spi	ecify: Wh	nite
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show fleat Eya cityst must be profithed at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Oc	cupation			16b. Kind o	of Business/Ir	ndustry
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pu	be file d oth even	Be	17. Father's Name (First, Middle, Last	")				18. Moth	er's Name	(First, Middle	, Maiden Sur	name)	
yla	ould Mer narke	ဥ	Luther H. Berry							Edna D			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extraction from the behaviored at once.		19a. Informant's Name/Relationship JoAnn Cooper / D			1	ng Address (Stre						
	1 and Healt em 2		20a. Method of Disposition	augnter	20h F					ate NOTE		, Mary on - City or T	land 21901
altimore,	ages ant of t: if it		14⊈ Burial 2 ☐ Cremation 3 ☐		ate A110	emetery, crem	sition <i>(Name of</i> natory or other p [emoria]	Park	Octob	er		-	Virginia
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U.	res that signed b be deta		Part II. Other significant conditions	contributing to deat	h but not res	ulting in the u	nderlying cause	given in Part	I.	23e. Did t	obacco use	contribute to	the cause of death?
rds	quires nn sig ald be	d by	Chravic Renal	Buzai	econcy	Hyp	ertens,	ON,		1 🗆	Yes 2 N	lo 3 🗆 Pro	bably 4 🗌 Unknown
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R	The It	Completed				•				autoj perfo	psy rmed? 2 No	prior to c death? 1 ☐ Yes	ompletion of cause of
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of V	hysic this ce al direc		examiner? 1 ☐ Yes 2 🌁 No	Hospital: 1 ☐ Inp	atient 2 🗌	ER/Outpatier	t 3 DOA	Other: 4 🗆 N	lursing Hor	ne 5 √ Resi	dence 6	Other (Spec	lfy)
n o	ding Ph h. After thi funeral	Certification: To	27. Manner of Death 1 → Natural 5 → Pending	28a. Date of (Month,	Injury <i>Day, Year)</i>	28b. Time of Injury	28c. Ir	njury at Vork?		28d. Describe			
sio	tendi leath. tor: / the fu	cati	2 Accident investigatio					□Yes 2□					
Division	I or Attendi after death. Director: A	if	4 Homicide determined	28e. Place of	Injury - At ho , etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, offic	e	2	28f. Location (City or To	Street and N wn, State)	umber or Ru	ral Route Number,
	pital		29a. Certifier TCCertifying P	hysician: To the be	est of my kno	wledge deat	a accurred at the	e time date a	and place	and due to the	causo(s) an	d mannor as	stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	miner: On the basi and manner	is of examina	ation and/or in	vestigation, in m	ny opinion, de	ath occurr	ed at the time,	date and pla	ice, and due	to the cause(s)
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			1 Land	6 -KO	(//	2	DOO	50002			Octob	07 10	2000
			30. Name and address of person who	completed cause	of death (Ite	723a) (Type,		59903			OCTOB	er 19,	ZUU9
	3		Dr. Pamela LeClai	re, 104 E	est Co	ecil Av	zenue, N	North E	East.	Mary1a	and 2	1901	
15 75. Tec	Sta	te	31 Date filed (Month Day Year)	32 Reg	istrar's Signa	ituro							
4.1	Registr	ar	OCT 1	9 2009 ▶	Brewn	1 1.	garke						

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CERTIFICATE

2009 - 34898

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CERTIFICATE #

2009-36904

State of Maryland / Department of Health and Mental Hygiene 34899 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Evelyn Gertrude Caple OCT 6:31 p 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1□ M 2🖔 F 1/16"/1920" Months Days Hours Min. 89 MD 220-05**-**1408 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Invoice Examiner must be notified at Director 1 ☐ Yes 2X No MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 12331 Southampton Dr. 21813 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ **1**No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No ò Q Specify 3 Widowed 4 □ Divorced Specify: white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Secretary Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finand Mental F Raymond Hyder Evelyn Bernice Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st Health and tem 27 is r 12331 Southampton Dr., Bishopville, MD 21813 Patricia Ann Sauter / daughter If item Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Zheimers **Physician** resulting in death) /Medical Due to (or as a cons quence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Exami and-trar physician a the burial-1 Due to (or as a consequence of): Box 68760 Physician/Medical e attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) 0 signed by the a □Yes 2□No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has birector, page 2 sl 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide nurse practionar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) PRMC 100 E. Carroll St Salisbury M2 21801 Savaçe RNP egistrar's Signatur State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Jean F. Davis Oct 2009 10:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare -The Pines Easton Talbot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. | Nov. 22, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 219-30-8611 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F 80 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location Caroline Preston 1 ☐ Yes 2 TNNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2731 Choptank Road 21655 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Medical Nursing Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harlan Franklin Davis, Sr. Nellie Lee Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22270 Havercamp Road, Preston, MD 21655 Nancy Jean Johnson/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Junior Order Cemetery 10/14/09 Preston, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a chine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year ٧n

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

MD

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be nutified at

event, the Medical

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Funeral

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Completed

Be

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

Maryland 21215-0036

Baltimore,

Jean

sician and burial-trans attending physician for use as the buria as reen signed by 2 should be detact within 24 hours

Division of Vital Records, P.O. Box 68760

Physician/Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 ■ 0 9 □ Unknown	d	I death 3 Ectopic			23d. Date of delivery Month Day	Year
Completed by Pt	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying o	cause given in Part I.	1 ☐ Yes 24a. Was an	o use contribute to the cause of 2 No 3 Probably 24b. Were autopsy findings prior to completion of	Unknov
	25. Was case referred to medical		1, , , , , , ,		autopsy performed 1 □Yes	death?	Jause 0
To Be	ovaminer?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D		ath (Check only one) Home 5 ☐ Residence	6 ☐Other (Specify)	
ation: 1	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factor ý)	y, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Nur ate)	nber,
Medical	29a. Certifier (Check only one) Certifying Physics 2 Medical Example 1	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	l at the time, date and place n, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
M	29b. Signature and title of certifier	MANUM	29	c. License number	29d. I	Date signed (Month, Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Mo

MD 610 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROWLEY

DUTCHMAN'S LANE EASTON, MD 21601

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 34901

		·	For State Registrar	State of Marylar	Cer	rtificate of i	neaith and iv Death		ene 2 0 0	9 34901
ì	Physici	an	1. Decedent's Name (First, Middle, Las	,	_			2. Date of Death Month October	17, 2005	3. Time of Death 11:00 P M
-10-8	/Medic		Bernard Arnold 4a. Facility Name (If not institution, give	Doepkens, Street and number)	<u>. </u>	4b. City, Town, or	r Location of Death	October	4c. County of D	
فمهر		٠.	St. Mary's Nurs	ing Center		Leonard			St. Ma	
	Funeral Director		5. Social Security Number 215–24–9206 Usual Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February 20	Year)	Birthplace (State or Foreign Country) aryland
	yland	·	10a. State 10b. County	10c. C	ity, Town or Loc	cation				10d. Inside City Limits
	Ba-f s	ector	Maryland St. Mar	ry's (Chaptic					1 ☐ Yes 2X No
	with th	Dir	10e. Street and Number 36111 Rooseve1	- R1wd		10f. Zip Code 2062 .	1	10	g. Citizen of What USA	Country?
	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, if a Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married	12. Was Decedent Ever in U Armed Forces? 1	J.S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, hite, etc.
21215-0036	ours af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2 No	Specify:		Specify:	White
15-0	n 72 ho "natu edicel	Completed	15. Decedent's Ed (Specify only highest grad	ucation ile completed)	i (Give I	lent's Usual Occup kind of work done o OO NOT use retired	durina most of work	ing 1	6b. Kind of Busine	ss/Industry
212	filed within Hygiene. Ither than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	nager	1)	9	ľobacco V	Varehouse
	hould be filed nd Mental Hygi marked other matic event, ti	Be	17. Father's Name (First, Middle, Last)	•			18. Mother's Name			
<u> </u>	should I and Men s marke umatic	ပ	Henry (NMN) Do	pepkens	10h Mailin	a Address (Street	Elizab			e, Zip Code) 20621
<u>⊠</u>	nd 2 sellth ar 27 is rtrau		Thelma Lucille Doc							aptico, MD
Baltimore, Maryland	E = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			sition (Name of natory or other place	tery 10/2		Dc. Location - City Bushwood	or Town, State
Balti	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lio-ns	-	22. M .	. Name and Addre		r Funeral	L Home, 1 MD 2065	P.A.
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. TER	mine	el Car	sherica	2		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	4	(1000
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	quence of):	wa				700
	ecuter and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	Tuongo of					
68/60,	rtificate be executed ng physician and as the burial-transit	calE		d	quence on.					
	E SO B	Medical	IF FEMALE:	u			-			
X R R	death ceri e attendin d for use a	sician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3□	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
7. O	t the de by the ached	Physic	1 □Yes 2 □ No 9 □ Unknown	9 Unknown	death 5	Other (specify) _				
	w requires that the desired been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
Records,	law requas been 2 shoul	Completed	Caronani	Antanio	۔ سع	N		24a. Was an	24b. Were	autopsy findings available
<u> </u>	The la ate ha	mo		1/1 org				autopsy performe	ed? deatl	to completion of cause of n? ∕es 2 □No
VITal	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		LOth		(Check only one)		
0	Phys er this eral dir	5.1	1 ☐ Yes 2 Ø No 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at	me 5 Residen		Specify)
0 0	anding ath. or: Afte	atior	1 Natural 5 □ Pending Continue 1	(Month, Day, Year)	Injury	Worl	Ŕ? Yes 2□No			
UIVISION	al or Atta after de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	iome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tile restigation, in my co	me, date and place, opinion, death occur	and due to the car red at the time, dat	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	0 10		29c. Licens	e number	296	d. Date signed (M	onth, Day, Year)
	PC		Pont.	st larva	ZM1	UD	06419		10-19-	-09
	8		30. Name and address of derson who call James P. Jarboe,	11			town, MD	20650	,	-
	Sta		31. Date filed (Month, Day, Year) 20	20 H 11 11 21 2		F-10-				
	Registra	ar	•		11					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 3. Time of Death 2. Date of Death **Physician** Year 2:20 pM Aswin Darwis October 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Director 71 May 10, 1938 Indonesia None Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show show 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene.
Int. If item 27 is marked other than "natural", or items 23a or 1
Int. The standard event, Ite Medical Example 11 interests and 11 interests and 12 interests and 1 10832 Antigua Terrace, #102 20852 Indonesia by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify. Specify 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Diplomat Foreign Affairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Darwis Diamin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troone. Hasnah Darwis - Wife 10832 Ontigua Terrace, #102, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Respoyal from State 4 ☐ Donation 5 ☐ Other (Specify) Indonesia T.P. Pondok Kelapa 10/20/2009 Nakarta-Timur, Indonesia 21. Signature of Funeral Service Livensoe 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 7 days /Medical Due to (or as a consequence of): Examiner Low Cardial Output 17 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of) burial-trans Large Acute Myocardial Infarction 17 days resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760 certificate be PM Physician/Medical Atherosclerotic Vascular Disease Years use as 30 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter for u The law requires that the death 3 Ectopic pregnancy Ye ar Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 6. 20 History of Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 8 Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an page 2 autopsy performed 9 1 ☐ Yes 2 No Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔼 Inpatient ၉ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 X Natural 5 Pending ASWIN investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Æ Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 16, 2009 10 AR 68474

State Registrar Michael Siegenthaler, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814
31. Date filed (Month, Day, Year) | 32_Megistrar's Signature |

19

OCT

30. Name and address of person who completed cause or death (Item 23a) (Type, Print)

32 Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** Calvin 9:50 A.M William Deems 2009 October 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dennett Road Manor Nursing Home Oakland Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Director 220-16-6873 April 21 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X□Yes 2□No Director Garrett Loch Lynn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 Roanoke Avenue 21550 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No à Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Area Manager Columbia Gas System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Injury or other traumatic 2 W. Irvin Deems Rennie Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau Margaret Deems, Wife 1113 Mary Drive, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/13/2009 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A Katherine Dureits 21 N. Second St., Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Vear Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an this certificate has autopsy performed? (es 2 No 1□ Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: after death. Director: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the death occurred at the time, date and place, and due to the cause(s) and due to the cau 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA5 Dr. Thomas G. Johnson 311 N. 4th Street, Oakland, MD 21550 31. Date filed (Month Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 34904 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 15, **Physician** 2009 10:10am M October 0 Kenneth M. Davis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country)
MD If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Feb. 15, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **X**□ M 2□ F 55 1954 218-46-2235 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Director Eldersburg MD Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 1307 Lee Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing 12 Print Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Carr John W.L. Davis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1307 Lee Lane Eldersburg, MD 21784 Mrs. Susan L. Davis (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 10/17/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as_a consequence of) Examine Due to (or as a consequence of) Physician/Medical IE EEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 ☐ Ectopic pregnancy Vear Month Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1 1 □ Yes 2 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2100 1 Dinpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, I within 24 hou To the Fune completely fil

Funeral

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating must be notified at

Physician

/Medical

To the I JL 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier malcolus dut,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anera

aman 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29d. Date signed (*Month*, *Day.* Year)

Wan-minster MD 2/157

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Month Year **Physician** DAGHAR AKIA 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** OCKVILLE SHADY GROVE ADVENTIST HOSP MONTGOMERY 9. Birthplace (State or Foreign Country)
KENYA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F Months Days Hours Min. 219-43-8610 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinations to notified at MONTGOMERY 1 Yes 2 No Director GERMANTOWN MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20874 LEAP TERRACE 115A 18161 STAGS Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumation. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: ARAB 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SALHA BINT MOHAMMED YUMEN DAGHAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 874 19a. Informant's Name/Relationship (Type. Print) 1816/ STAGS LEAP TERRACE GERMANTOWN MD SAMIR 20a. Method of Disposition 10 16 09 FREDERICK 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL 21. Signature of Funeral Service Licensee EASY STREET, WOUDBRIDGE VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician OVAYIAN Montes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEKS monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Diabetes rears and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached f 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier tracertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier N67405. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SADIA 1000 CENTER OR MASOOD MEDICAL ROCKVILL

Registrar

State

31. Date filed (Month, Day, Year)

OCT 1 9 2009

32. Registrar's Signa

State of Maryland / Department of Health and Mental Hygiene 34906 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Garnet Woodson Dickens, October 0 22 2009 2010 Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Care and Rehabilitation Center Elkton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 224-54-6907 May_27 . 1940 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evar invertment be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐Yes 2 X No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1973 East Old Philadelphia Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Security Officer Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Wesley Dickens Hazel Virginia Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21921 Patricia Dickens/Wife 1973 E. Old Philadelphia Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State October 0 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26, 2009 Elkton, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DIVALO disease or condition resulting in death) /Medical Due to (or all a consequence of): **Examiner** erebroupso Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Be Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

• Funeral Director: A

pletely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) w main St. Elkon, MD Name and address of perso completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State of M	larylan	d / Depa	artment rtificate	of Hea of De	alth and I Path	Mental Hy	giene, Reg. No.	2009	34907
P	Ob		1. Decedent's Name (First, Middle	, Last)						2. Date of De			3. Time of Death
	Physic /Medi		Lucille Wolley	v Evans						October	14,	2009 Year	5:00 A. M
	Exami		4a. Facility Name (If not institution	give street and number,)		4b. City, 7	Town, or Loc	cation of Death	1	4c. C	County of Death	
			Heartland of Hya					attsv				ince Ge	
1	Funeral Director		577-56-0548	1 M 2 F	ge (<i>In yr</i> s 59	last birthday) Yrs.	Months		Under 24 Hrs. lours Min.	8. Date of Bird (Month, Da 01/11/	th y, Year) 1940	Cou	place (State or Foreign Intry) , D.C.
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
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	the N 28a-	Director	Md. P. 10e. Street and Number	.G.	D3	istric	10f. Zip		-		10a Citiza	en of What Cou	A
	3a ol	Ö	1606 Forest B	Park Drive					0747		J	U.S.	
	death ms 2 r mus	Funeral I	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Deced	ent of Hispa	nic Origin? (S	pecify Yes or No o Rican, etc.)	- 14	4. Race - Amer	can Indian,
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces: ed 1 Tyes 2 Tyes If Yes, Give Year or Dates:			nr Yes,speci 1∐ Yes 2		pecify:	o Rican, etc.)		Black, White Specify:	, etc. Black
9-0	72 hours "natural"; edical Exa	Completed	15. Decedent' (Specify only highes	s Education		16a. Dece	dent's Usual	Occupation	n ng most of wor	(-i	16b. Kind	d of Business/Ir	ndustry
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	e retired)		King			
21	e filed wall Hygier other the	ပ္ပ	12th			Rec	gistry	/ Cler					l Service
Maryland	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, L Willie Wolle	,				18.		ne (First, Middle, ia Jamis		lurname)	
ary	2 should be and Mental is marked or raumatic ev		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address	(Street and	Number or Ru	ral Route Numbe	er, City or	Town, State, Zi	p Code)
Σ,	and 2 ealth a n 27 i		Debra Y. Forres	st/Daughter		1606	Fores	st Par	k Dr.,I	District	: Hgts	s.,Md.	20747
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from State	20b. P	lace of Dispo emetery, crei	sition (Nam natory or ot	e of her place)	i t	Date	20c. Loca	ation - City or T	own, State
Ë	. Pag tment tant: Jury o		4 ☐ Donation 5 ☐ Other (Sp	ecify)		cmony I	Mem. F	ark	10/2	1/09	Land	dover,M	aryland
Bai	permit Depar Impor any in once.		21. Signature of Funeral Service L		_	22	. Name and H.S	Address of Wash	Facility ington	& Sons	Co.,]	Inc.	
	ED = 10 0		Parry of		el Alo	49	325_Bu	irroug	hs Ave	N.E.W	ashir	ngton,D	.C. 20019
			23a. Part1. Enter the disease, or on shock, or heart failure. List of Immediate Cause (Final	only one cause on each li	ine.	1. Do not ent	er the mode	or ayıng, sı	uch as cardiac	or respiratory ai	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-a - C+16	-DIO	rulin	Beel	127	TOP	[23			
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P.O.	uires that the de signed by the a Id be detached f	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			1 other tope						
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rd	w require been sig should b	ed b								1 🗆 \	′es 2□	No 3 ☐ Pro	bably 4 🗹 Únknown
Records,	ie law requ has been je 2 should	Completed								24a. Was		24b. Were aut	opsy findings available
<u> </u>	The parties of the pa	Ĕ								autop perfo 1⊟ Yes	rmed?	death? 1 ☐ Yes	ompletion of cause of
Vital	Physician: Th this certificate ral director, paç	Be (25. Was case referred to medical examiner?						Place of Deal	th (Check only o			
or		P	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatien			Mursing H	ome 5 Resid			fy)
no	ding I. After fune	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	M 28	c. Injury at Work?	0.00	28d. Describe h	ow injury	occurred	
Division	I or Attending after death. Director: Afte I in by the fune	licat	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Place of ini	urv - At ho	me, farm, stre	1	1 ☐ Yes	2 🗆 100	28f Location /9	Stroot and	Number or Rus	al Route Number,
Ö.	all or / after I Dire d in b	Certification:	4 Homicide determin	building, et	tc. (Specify)	, , ,			City or Tou	n, State)	reamber or rear	ar riodie Namber,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	Physician: To the best	of examinat	wledge, death tion and/or in	occurred a	t the time, d	late and place on, death occu	and due to the orred at the time,	cause(s) a	nd manner as solace, and due	stated. to the cause(s)
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_	12	+	30. Name and address of person w	ho completed cause of d	leath (Item	23a) (Tvne	Print)	10				7-16	, , , , , ,
1_	10		VIGOL ONY 31. Date filed (Month, Day, Year)	ELIAKA -	7321	SAH	Aced	IELP	ORKINA	y GRE	GEBE	eli Mi	78-1 Lang 20770
	Sta Registr		OCT 1 9 2009	Denewa &	ars signat	west							

State of Maryland / Department of Health and Mental Hygiene 2 1 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, 2009 **Physician** F1amboe Elvira Estelle 1:50 pm October /Medical 4c. County of Death St. Mary's 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hollywood 23914 Meredith Ct. 8. Date of Birth (Month, Day, Year Sept. 11, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Days Hours 1 □ M 2 🌣 F Sept. Texas 521-01-5232 1912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State the Marylar show ns 23a or 28a-f shov 1 ☐ Yes 2 No Director MD St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with United States 20636 23914 Meredith Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates Specify: Completed by Specify: White 3 Nidowed 4 Divorced 'natural", the Medical 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Julia Almquist Carl Youngren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Edward E. Flamboe 23914 Meredith Ct., Hollywood, Maryland 20636 Health at tem 27 ls 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/16/2009 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A, 21. Signature of Funeral Service Licensee Kyle Simons MO 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Maheiner **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by failure to thrive, 1 ☐ Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Tile of certifier 10/15/0 00055682 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an MD 20650 130 log Kler Leanardtown Thomas Wilkinson, M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34909 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2009 October 8:20 a M Vaselee Freeman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Great Mills 45835 Church Drive St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Days Hours Director 218-38-8107 12/30/1937 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10a State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45835 Church Drive Funeral 20634 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: 2 Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9 Concrete Mason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Walker Freeman Venus Nora Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Davis/Niece P.O. Box 2358, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre10/21/2009 Charlotte Hall, MD 21. Signature of Funeral Service sice e 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Danielle Ward 22955 Hollywood Rd., Leonardtown, MD 20650 M01403 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) uekrd /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off burial-transif Due to (or as a consequence of) physician the burial Box 68760, certificate be Physician/Medical as attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Гoг Month Year Day 5 ☐ Other (specify) been signed by the should be detached o 9 Unknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Dres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No After this certificate 1 ☐Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \sum Nursing Home 1 Yes 2 No 5X Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending Injury death. Investigation 1 □Yes 2 □ No Director: 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-19-02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Daniel Howell, M.D

31. Date filed (Month,

2. Registrar's Signature

24035 Three Notch Road, Hollywood, MD 20636

State of Maryland / Department of Health and Mental Hygieneo

			1 - For State Registrar	State of Ma	ar ylaria / L	Cer	tificate	of De	eath	wientan ny	Reg. N		34910
	Physicia	an	Decedent's Name (First, Middle, La						_	2. Date of D		ay Year	3. Time of Death
	/Medic	al	Richard Patrick (•				-		r 10	6, 2009	2:10 A M
	Examin	er	4a. Facility Name (If not institution, given St. Mary s Hospit	,					ocation of Deat		4	c. County of Deatl	_
	Funeral		5. Social Security Number 6. 8		e (In yrs. last bir	thdav)	If Under 1		ardtown FUnder 24 Hrs		rth	St. Ma	hnlace (State or Foreign
	Funeral Director			1⊠M 2□F		Yrs.	Months [Hours Min.	March	ay, Yea 17,1	946 Dist	hplace <i>(State or Foreign</i> <i>untry)</i> cict of Columbi
	fand wo		10a. State 10b. County		10c. City, Town	n or Lo	cation						10d. Inside City Limits
	Mary First	ţċ	Maryland St.	Mary's			Lev	ingto	n Park				1 ∐ Yes 21∑ No
	or 28g	ire	10e. Street and Number				10f. Zip C		JII I GIR		10g. C	Citizen of What Co	untry?
	th wit	Funeral Director	21013 Great Mills	s Road Uni	it V1		2	20653	3			USA	
	ems	nei	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Deceder	nt of Hispa	anic Origin? (S Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White	rican Indian,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madreal Evantinar must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ∐Yes 2 ⊠ N If Yes, Give Year or Dates:	10		I∐Yes 2∑		Specify:	,		Specify:	White
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2	Hygie Hygie ther 1		10 17. Father's Name (First, Middle, Last	*)		Au	to Med	-		me (First, Middle			.ve
2	d be ental	To Be	Prily I. Gatton,	•						Shirley			
	shoul nd M marl mati	F	19a. Informant's Name/Relationship		19b	. Mailin	a Address (S	Street and				or Town, State, 2	Zip Code)
Ž	nd 2 alth a 27 is 27 is ir trau		Shirley M. Davis									od, MD 2	, , , , ,
5	s 1 a		20a. Method of Disposition		20b. Place of cemeter	Dispo	sition (Name	of or place)		Date		Location - City or	
	it. Page rtment or rtant: If njury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	fy)	1	lita	an Crema	atory	20	oer 19, 09	Ale	xandria, V	irginia
3	permi Depar Impor any ir		21. Si nature if Fungral Service Lic	Gardiner)	22	Matting P.O. Be	gley-(ox 270	or Facility Gardiner O Leona:	Funeral I	Home,	P.A.	
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	prications that caused	the death. Do	not ent							Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Mul	HO	50	Jay		rilur				Onset and Death
É.	/Medical Examiner		resulting in death)		a consequence		,						
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	uted insit	m in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	End	C.+O	00	(OF	D				
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	eath cer attendir for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		з Г	Ectopic pre	anancy				23d. Date of del	
5	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (spec					Month	Day Year
	ires that the de signed by the a I be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to dooth by		- the			in Donal	age Did	tabaaa	. ugo gostributo to	the cause of death?
5	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by		contributing to death bu	at not resulting in	i trie ur	ideriying cau	ise given i	ın Part I.				robably 4 Unknown
	law re as be 2 sho	Completed								24a. Wa	s an opsy	24b. Were au	stopsy findings available completion of cause of
	hysician: The law his certificate has t il director, page 2 s'	No.								per 1 □ Yes	ormed?	death?	2 No
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	after after Dire	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	iii, suc	set, lactory, o	niice		City or To	wn, Sta	arid Number of Hi ate)	ural Route Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination ar	e, death	occurred at vestigation, in	the time,	date and plac	i e, and due to th urred at the time	e cause	e(s) and manner as and place, and due	s stated. e to the cause(s)
	o the	Mea	29b. Signature and title of certifier	and manner sta	ited.			License ni				Date signed (Mont	
	⊢ ≶ F ŏ		· ARIV	ah			17)		66		0-16	
			30. Name and address of person who	completed cause of di	eath (Item 23a)	(Tyne I	Print)		-1 [-		- 1	0 10	
			Avani D. Shah, M.D.				, i		- 16n c	0000			
	Sta	te	31. Date filed (Menth Day 1997) 20	22650 Ceda 32. Registra	ar's Signature	JOH	Leon	nardto	own, MD 2	10650			
	Registr	ar	001 19 20	an Center	10.1	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Deceden s Name (First, Middle, Last) 10 2009 ~cent 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death a Plata harte Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
5/11/1426 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Min 1 9M 2 □ F 83 20-26-6830 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Tes 2 ☐ No Prince Marybul 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 454 Olal 13105 20613 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 TONo Specify: Black 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Openter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd Head (M) 20613 huelle 3/05 Hard hel 122 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MI) Intrul 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneta Service Licenses 22. Name and Address of 70608 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 77157 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 ☑ No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi Division of Vital Records, P.O. Box 68760, physician attending pl

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra

Physician

Examiner

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mential Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, it a Medical Entruly at must be rediffed at

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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To the Funeral Director: A
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1∐ Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Cert

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite

State Registrar

32: Registrar's Signature 31. Date filed (Month, Day, Year) 162009

within 2

BBLo

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gregory B. Gally October 2009 /Medical 04:00 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 08/23/1942 216-42-2614 9. Birthplace (State or Foreign **№** М 2 🗆 F Months Days Hours **Director** 67 Calĭfórnia Usual Residence of Decedent 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Invition Event in the Invition of 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. 10f. Zip Code 10g. Citizen of What Country? 113F Bloomsbury Square 21402 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give N Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 1 □Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United States Postal Clerk Postal Service 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Brainard Gally ည Erené Gregory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gally/Brother 4302 Detonty Street, St. Louis, MO 63110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If it any injury or c 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 10/14/2009 Edgewater, Maryland 21. Signature of Farjaral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home U 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hock /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician a s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy n signed by the a Id be detached for ☐Yes 2☐No 5 ☐ Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 2 **N**O 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 24 hours a Funeral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) assensed MO Anne Avundel State 32. Registrar's Signature 15 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Day 12:30 P.M Curtis Ray Glotfelty 6, 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5074 Kempton Road 0akland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 🔀 M 2□ F Director 219-46-2045 63 01/31/1946 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 X No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? nd 2 should be filed within 72 hours after death with 1 lith and Mential Hygiene. 27 is marked other than "natural", or Items 23a or 2 traumatic event, the Medical Examination must be m 5074 Kempton Road 21550 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Miner Coa1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linky or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Glotfelty ၉ Ethel Glotfelty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marilyn Glotfelty, Wife 5074 Kempton Road, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Cemetery 10/09/2009 Garrett County, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown entel 910m 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1 ☐ Yes 2 X No certificate funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1∐Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Assidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation thours after death. uneral Director: A ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D15333 10,8,9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, 311 N. 4th Street, Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	ental ental ked o	To Be	Norman H. Gates				_	Katie Jo				
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			shock, or heart failure. List Immediate Cause (Final	only one cause on e	o LOA		CARC					Interval Between Onset and Death
	hysician / /Medical		disease or condition resulting in death)	a.	(or as a conseq		CHIKOI	, , ,				
E	Examiner			b. ———								
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	al Director	WV Tucker 10e. Street and Number HC 60 Box 26	Tł	nomas	10f. Zip Code 26292				Sitizen of What Cou	Y Yes 2 No
900	ours after dea rrai", or items Examiner m	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Deceder Armed Force: 1 Yes, 2 If Yes, Give Year or Dates	XNo	S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 X No		n? (Specify Yes o Puerto Rican, etc	r No-)	14. Race - Ameri Black, White, Specify: Wh	etc.
Baltimore, Maryland 21215-0036	ed within 72 h ygiene. ier than "natu t, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o	r 5+)	(Give life.	edent's Usual Occu e kind of work done DO NOT use retire emaker	during most of		0	Kind of Business/Ir	dustry
aryland	i 2 should be filed wir n and Mental Hygien is marked other th raumatic event, <u>the</u>	To Be	17. Father's Name (First, Middle, Last) Isaac Arn 19a. Informant's Name/Relationship (Type. Print)	old	19b. Mail	ing Address (Stree	Lula	May Fi	ke	en Surname) r or Town, State, Zi	o Code)
nore, Μα	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trai		Marsha Moats 20a. Method of Disposition 1□ Burial XX remation 3□ Removal from State	.e .	lace of Disp emetery, cre	osition (Name of ematory or other pla	ice)	Date	20c. l	cora, W\ Location - City or T	own, State
Baltin	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) 21. Signature of Juheral Service Linguise 9. Supplies Tunkle	Ome	2	remator HimkTe ^{ddr} POBox 1	Fuhera	al Home		organto 60	wn, wv
	Physician /Medical Examiner			ed the death line.	hece	iter the mode of dy	ing, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Berween Once and Death
8760,35	cate be executed ohysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events c.	is a consequ	,						
.O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	□Ectopic pregnanc □ Other (specify) _	şy		- 111.2	23d. Date of deliving Month	ery Day Year
ords, P.	The law requires that the de ite has been signed by the a lage 2 should be detached f	by	Part II. Other significant conditions contributing to death	but not resu	ılting in the u	underlying cause gi	ven in Part I.				the cause of death?
Vital Records,	(0 17	e Completed	25. Was case referred to medical				26 Place of	;	\sim	prior to co death?	opsy findings available ompletion of cause of
Division or Vi	ding Phy After this funeral d	ation: To Be	examiner? 1 Yes 2 No	ijury	ER/Outpatie 28b. Time o Injury	of 28c. Inju	her: 4 🗆 Nursi	ing Home 5 🗆 l 28d. Desc	Residence	6 ☐Other (Special Control occurred)	fy)
DIVIS	i de de	Il Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of i building, 29a. Certifier 1 ☐ Certifying Physician: To the beautiful physician and the place of the building.	etc. (Specify	′)	reet, factory, office	ime date and r	City o.	r Town, Sta		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exampler: On the basis and manner 29b. Signature and title of certified	of examinat	tion and/or in	29c. Licen	se number	occurred at the t	29d. D	pate signed (Month)	to the cause(s)
	Sta Registr		30. Name and address of person who completed cause of Robert A. Goralski, M.D. 31. Date filed (Month, Day, Year) 32. Regis		N For	Print)		cland, M			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10 2 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Forestville 6614 Lacona Street 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1**Z** M 2□ F 10/13/1920Yrs. 88 Director 135-14-6301 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Maryland Prince George's Forestville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20747 6614 Lacona Street Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by F 1 □Yes 2 🛣 No If Yes, Give Year or Dates: 1942–45 Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If item 27 is marked other threamy injury or other traumatic. Federal Government Management Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Anne Hegarty Walter Harrison Hannan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne M. Hannan/Wife 6614 Lacona Street, Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 10/19/2009 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George F. Kalas Funeral home 21. Signatur Poper ervice icensee 101 6160 Oxon Hill Road, Oxon Hill, MD 20745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine y physician and is the burial-transit be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as use as IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) P.0. ed by the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has autopsy performe certificate 2 🗆 No 1 ☐ Yes 2 Z No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Bescribe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number Name and address of pers no completed cause of death (Item 23a) (Type, Print) ENTAM 1) FENSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 6 6

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Meredith C. Harshman/son 10327 Clark Road, Myersville, Maryland 21773 20a Method of Dispectation 3 Demonstration 3	hould d Mel narke	မို	110111111111111111111111111111111111111		I Oh Mailine	Address (Street				
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23s Part Emythod deapton Deepth	artme ortani Injury			-	22.	Name and Addres	ss of Facility	50/	Main Stre	et
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Section lay list conditions Section lay list conditions	Physician /Medical		disease or condition resulting in death)	totatie		ne	eaucer			
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The part of the pa	he death ce the attendii shed for use	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 220. If yes, of 1 Live 4 Pregnant 1 Pregnant 23c. If yes, of 1 Live 23c. If	birth 2 □Fetal de nant at time of deatl	ath 3 🗌					
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1 Yes No No No No No No No N	w rec	lete						24a. Was ar	24b. Were a	utopsy findings availat
25. Was case referred to medical examiner?	he la e has age 2	E G						perform	y prior to ned? death?	completion of cause o
The property of the property o	an:] tifical tor, p		25. Was case referred to medical				26. Place of Deat			\$ 24/11/0
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Manzar J. Shafi, MD 368 Mill Street Hagerstown, Maryland 21740	ig Ph ter th					28c. Injur	y at			
Manzar J. Shafi, MD 368 Mill Street Hagerstown, Maryland 21740	afh. or: Af	atio	2 Accident investigation	, 24, 104,	,,	I				
Manzar J. Shafi, MD 368 Mill Street Hagerstown, Maryland 21740	alor Att after de I Drecte dir by t	ertific	dotorminod 200. Flac	e of injury - At home ding, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,
Manzar J. Shafi, MD 368 Mill Street Hagerstown, Maryland 21740	e Hospiti 24 hours e Funera etely fille		(Check only 2 edical Examiner: On the	basis of examination						
Manzar J. Shafi, MD 368 Mill Street Hagerstown, Maryland 21740	o the	Me				29c. License	e number	29	d. Date signed (Mor	nth, Day, Year)
30. Name and address derson who completed cause of death (Item 23a) (Type, Print) Manzar J. Shafi, MD 368 Mill Street Hagerstown, Maryland 21740	- s - ō		> dlangen I me	el		D-28	365		10-26	-09.
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			30. Name and address ferson who completed cau			Print)		own, Mary		
Registrar OCT 3 0 2009 Peners A. Aparks	Sta	at <u>e</u>		Registrar's Signature	1 =	1.11				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 34918 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Virginia Elizabeth Huffer 20**09** October 19. 5:40 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Citizens Care & Rehabilitation Center Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 24, 1921 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days Hours Min. Months 215-26-1514 1 □ M 2 🕅 F 87 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Frederick Maryland Knoxville Director 1 ☐ Yes 2 K No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3308 Carlisle Drive 21758 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14 Bace - American Indian 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. \$ Specify: White 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Silas Hale Mabel Merchant ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Richard Hale / Nephew 3308 Carlisle Drive, Knoxville, Maryland 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 27 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Jefferson Methodist Cemetery Jefferson Maryland 4 □ Donation 5 □ Other (Specify) 2009 21. Signature of Funeral Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 mor Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐Yes 2 ☐No 1 □ Yes Be Certification: To

Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, Hospital or Attending

burial attending physician for use as the buria signed by the a has page 2 certificate After thi ours after death.

neral Director: A filled in by the formula within 24 hours a

To the Funeral D Medical completely

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

death with the Maryland

within 72 hours after

filed within 7 I Hygiene.

d 2 should be filed w th and Mental Hygie 7 is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

examiner?	edical		26. Place of Dea	ath (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ In	patient 2 ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 ☐ Residence	e 6 ☐ Other (Specify)	
2 ☐ Accident in	vestigation	Injury 28b. Time of Injury N	28c. Injury at Work?	28d. Describe how in	njury occurred	
	ould not be etermined 28e. Place of building	f Injury - At home, farm, street, fa, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)	
29a. Certifier 1 Cer (Check only 2 Med one)	tifying Physician: To the backing Examiner: On the backing and manner	est of my knowledge, death occ sis of examination and/or investion or stated.	urred at the time, date and place gation, in my opinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)	
29b. Signature and title of ce	ertifier		29c. License number	29d.	Date signed (Month, Day, Year)	
	swit .	MD	D5839	0	ctober 19, 2009	

State

Registrar

Name and address of person

ompleted cause of death (Item 23a) (Type, Print)

ve, Frederich, M 21701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Betty Jane Janney 8:12 2009 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Carroll Manchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M Director 85 217-34-2916 May 11 1924 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinor must be rediffed at Director Carroll 1 ☐Yes 2 ☑ No MD Manchester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4011 Doefield Drive 21102 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ould be filed w...
d Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>own home</u> <u>homemaker</u> if Health and Mental Hygie item 27 is marked other item traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Pietro Amodio Virginia Lois Miles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie M. McCleary, daught, 4011 Doefield Dr., Manchester, Md. 21102 item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Memorial G. 10/19/09 Bel Air, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home demmer M00741 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call of near the mode of dying, such as cardiac or respiratory arrest, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eumonia luks /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. signed by the attending physician the detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death I ☐ Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 2 □ No 1 □ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No after death 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) WIL nd address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34920 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 2009 250 October 24 SAIL ORDAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burnie Baltimore Wyshington Medical (Frita Anne ale~ Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | Min. | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Day, | Month, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗹 F 212-60-3715 MARYLAND Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Experient must be notified at 1 ∐Yes 2 🗹 No by Funeral Director PASADENA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 607 ELIOT RD ZII اکھ، ک. *و* Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AVIATION CONTRACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SSIE MAE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 607 ELIOT RD. PASADENA, A Date Important: If item 27 is any Injury or other trau once. MD-21122 JORDAN, HUSBAND 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department 4 ☐ Donation 5 ☐ Other (Specify) ARUNDELCREMATORY 10-26-09 OSENTON, MD 21. Signature of Furral Service icense 22. Name and Address of Facility DAUGHERTY FUNERAL HOME 2601 HOUNTAIN RD. PASADENH, MD 21122 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VON SMAIL (c11 Physician Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was at autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No icate has b , page 2 st 24a. Was an 1 ☐ Yes or Attending Physician; funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ŽÎNo 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 4 hours after death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

RANCIS

31. Date filed (Month, Day, Year)

OCT 3 0 2009

Washington Mesical Center

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Lawanda Joyce Krause October | 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Goldsboro Caroline 15326 Greensboro Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, | Aug. 22 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Mary land Director 215-30-3384 76 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho the Medical Examination ust be notified at Goldsboro Caroline Director Maryland 1 ☐ Yes 2 Z No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21636 15326 Greensboro Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: or i 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: ş 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. catholic school sys teacher nd 2 should be filed wath and Mental Hygier 27 is marked other the traumatic event, the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any Injury or other traumatic evo Iva Mae Manning Joseph Frank Long 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15326 Greensboro Road; Goldsboro, Maryland 21636 Norman F. Krause/ husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 9, 2009 Greensboro Cemetery Greensboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home PA PO Box 160; Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending p IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the Ö 9 Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? aw 24a. Was an cate has by page 2 s autopsy performe The certificate 2 No 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Watural 5 Pending Injury death. 1 □ Yes 2 □ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the Signature and title of certif 29d. Date signed (Month, Day, Year) ဂ္ 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

OCT 0 9 2009

			1 - State of Maryland / Department Certificate	of Health and Me of Death	ental Hygiene	2009	34922
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physic		Edward M. Kelly		Month Day	y Year 0, 2009	9:21 P M
	/Medi Examiı		4a. Facility Name (If not institution, give street and number) 4b. City, T	own, or Location of Death		County of Death	7.211
1			Anne Arundel Medical Center Ann	apolis		Anne Aru	ndel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 17224838 Is M 2 F PO Yrs.	Davs Hours Min.	B. Date of Birth (Month, Day, Year)		lace (State or Foreign try)
	Director		1/4-22-4838		9/4/1929	Penn	sylvania
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		·	10	Od. Inside City Limits
	Maryl f sho	ō					1 □Yes 2 No
	the 28a	rec	Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip (Code	10g. Cit	izen of What Count	trv?
	3a ol	by Funeral Director	858 Inverrary Ct. 2	1401		USA	•
	death	ner		ent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - America	
9	after or ite	F	1 □ Never Married 2 🕅 Married 1 🕅 Yes 2 □ No 1946 −		ican, etc.)	Black, White, e	
203	72 hours after death with the Maryland natural", or items 23a or 28a-f show		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1966	діно зресііу:		Specify: Whi	te
Maryland 21215-0036	72 h "natu	Completed	15. Decedent's Education 18a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	Occupation done during most of working retired)	16b. Ki	ind of Business/Ind	ustry
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an	d be ental ked o	To Be	Edward Kelly		nce Ruskau	ŕ	
ar.	shoul nd M mar	1		Street and Number or Rural			Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan, included the redifficults. Once.		20a. Method of Disposition 20b. Place of Disposition (Name	e of Da		ocation - City or Tov	wn, State
Ē	Page nent unt: If ury or		In burial 2 Li Cremation 3 Li Removal from State		-09 Ar1	ington V	17 A
alti	permit. Departr Imports any Inju		4 Donation 5 Other (Specify) Arlington Nat. 21. Signature France 22. Name and	Address of Facility Geo	rge P. Kal	as Funera	al Home
<u>m</u>	8 3 E 8	0 0	2973 S	olomons Islan	d Rd. Edge	water, M	21037
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
4	Physician	1	Immediate Cause (Final disease or condition	nathy			Onset and Death
3	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1			
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	ted isit	ie	for a suppose the cause. Enter Underlying Cause (Disease or injury				
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687	ificate g phy as the	edical	0.				
Вох	eath certifi attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		Į.	23d. Date of delive	ry
	deat e atte	icia	in the past 12 months? 1 Dive Signature of death 3 Dectopic present at time of death 5 Deter (spe	egnancy c <i>ify)</i>		Month	Day Year
P.0	that the dended by the detached	h/s	9 □ Unknown				
	ires tha signed I be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cat	use given in Part I.	23e. Did tobacco u	ise contribute to the	e cause of death?
ord	w requir been s should	te	dementia.	· · · · · · · · · · · · · · · · · · ·	1 ☐ Yes 2[□ No 3 □ Proba	ably 4 ☐ Unknown
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<u>=</u>	The l	ő			performed. 1 ☐ Yes 2 🗷 No	death?	
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)		
of Vital Records,	Phys this al dir	은	1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28		e 5 Residence)
	or Attending Physician: after death. Director: After this certifici in by the funeral director, p	Certification:	Natural 5 ☐ Pending (Month, Day, Year) Injury	Work?	d. Describe how injur	y occurred	
Division	Attended death ctor:	fical	3 Suicide 6 Could not be 280 Place of Injury. At home form street feature	1 ☐ Yes 2 ☐ No	f. Location (Street an	d Number or Puml	Pouta Number
Di	after after Direct	erti	4 Homicide determined building, etc. (Specify)	511100	City or Town, State)	riodie Nambel,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred a	t the time, date and place, ar	nd due to the cause(s)) and manner as st	ated.
	he Hc in 24 he Fu pletel	Medical	(Check only one) 2	n my opinion, death occurred	d at the time, date and	l place, and due to	the cause(s)
	To the vithing complete the com	Ž	29b. Signature and title of certifier 29c.	License number	29d. Dat	te signed (Month, D	Day, Year)
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(1+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				-
(RIJ		31. Date filed (Month, Day, Year) OCT 15 2009 Menus B. Sank				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Repistrar's Signature OCT 15 2009	,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. For State Registrar 34923 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Kirk Cynthia Louise October 13 2009 9:31a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Westminster Dove House Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F 236-32-5659 86 7/1/1923 MD Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Eventral must be notified at 1 ☐ Yes 2 ☑ No Director Carroll Manchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Pages 1 and 2 should be filed within 72 hours after death with 21102 2922 Warehime Road USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2√2 No Specify: Specify: white ģ 3 Widowed 4 ☐ Divorced 'natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Bank Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stationery clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Thomas Jones Anna Miller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other traionce. 2922 Warehime Road, Manchester, Md. 21102

De of Disposition (Name of Date 20c. Location - City or Town, State Mary A. LaMar-Lang, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 10/14/09 Hampstead, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 S. Main Street, Hampstead, Md. 21074 panda Lemmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ance **Physician** 0 ta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stauchne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ 100 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Ulmknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗖 N 1 ☐ Yes 2 19No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1000 1 | Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Howe 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title o 0054218 10-13-2009 WJZ ne and address of person who completed cause of death (Item 23a) (Type, Print) K. Kaman B. Kanewa, 349 M 7 349 Malcalm dure, Westminter MD Kaneuk 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene 2009 34924 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician -23PM ASSEM LENE 2009 /Medical CENTER 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CHARLES COUNTY NURSING 4 RE HAB
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) CHARLES 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Months Min. 577-76-8515 Days Hours 70 Yrs 1939 ENGLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ahow the Madical Examiner must be notified at 1€ Yes 2 No MD CHARLES Funeral Director WHITE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4830 2069 SM17 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) NURSE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be JACKSON SIRYL MARGARET and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 8340 LN. PORT UMAR SON TOBACCO MD. 20672 Baltimore, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State injury or 10/17/09 FALLS CHURCH VA Depertment Importent: If any injury or once. National Mam. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beller STWOODRRIVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): unknown /Medical Examiner Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š cate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospitel or Attending 1 Natural Injury 5 Pending death. 2 Accident 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20746 completed cause of death (Item 23a) (Type, Print) HUSSEIN M.D SALLENTOWN RD. # 101 CAMP SPRINGS 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2000

	1	For State Registrar		•	Cer	tificate of I	Death		Reg. N	2009	34923
	_	1. Decedent's Name (First, Middle, La	st)					2. Date of Do	eath	Day Yeer	3. Time of Death
Physician /Medical	-	Georgia Garn	et Kolb							5 2009	2:20 p.M
Examiner		a. Facility Name (If not institution, given	re street and number)			4b. City, Town, or	Location of Death		4	c. County of Death	
		Oakland Nursin					akland I If Under 24 Hrs.	1000		Garre	
Funeral Director		i. Social Security Number 216-22-7480 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. lasi 79	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Oct. 1	ay Yea	r) Coun	lace (State or Foreign try) Llmar, MD
and w	-	0a. State 10b. County		10c. City, T	own or Loc	cation				1	0d. Inside City Limits
Mary f she	5	WV Minera	.1		F11 C	arden					1 ☐ Yes 2 🔯 No
vith the Mary t or 28a-f shu to rotified	2	0e. Street and Number	I		ETK G	10f. Zip Code			10g. C	Citizen of What Coun	try?
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fter death v r items 23s incr.must.	1	Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H		pecify Yes or N	0-	14. Race - Americ	
II'', o	\$	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			Yes, specify Cuba		Hican, etc.)		Black, White, e	ite
72 ho		15. Decedent's E (Specify only highest gr	ducation	1	6a. Deced	ient's Usual Occup	ation	vina.	16b.	Kind of Business/Inc	dustry
ed within 72 hou ygiene. In the Medical Et, the Medical E	-	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. E	OO NOT use retired	t)	ang	Ì		
ed will ygier ygier to the transfer the tran	5 -	12			_	Waitre				Restauran	ts
be fill Hall Hall Hall Hall Hall Hall Hall H	í	 Father's Name (First, Middle, Last)				18. Mother's Nam	ie (First, Middle	e, Maide	en Surname)	
Ould I Men arke Tatic		Blaine Helmick		r				Cunning			
d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship	**							or Town, State, Zip	Code)
Healther 2 ther	-	Jeannie Hanlin/I	aughter	20h Plac		1, Box 2		arden, Date		26717 Location - City or To	wn State
nt of int of or or or or or or or or or or or or or	ľ	1 ☑ Burial 2 ☐ Cremation 3 ☐		cem	etery, crem	sition (Name of natory or other place	Oct.			•	
if. Particular injury	-	4 ☐ Donation 5 ☐ Other (Special		I.0.	0.F.	Cemetery Name and Address				Elk Garden	, WV
permit. Pages 1 and 2 s Department of Health an Important: if item 27 is any injury or other trau	1	21. Signature of Funeral Service Lice	ullh			85 S. Mai	in Street	-	er,		
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death. I ne.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician	- 1	Immediate Cause (Final disease or condition	use Use	かった							acon the
/Medical Examiner		resulting in death)	Due to (or as		ce of):	0 15	1	701	^	1	
		Secuentally list conditions	b. End	Sp	re 1	Echal Fa	ilune Vi	HAIN	1)0	2(451)	year
ine sit		f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):	Λ_	There vi				
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ertificate be fing physicia e as the buri			_d								
		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	ath 3 □	Ectopic pregnanc Other (specify)	у			23d. Date of deliver	ery Day Year
by #		9 Unknown	9 ☐ Unknown								
: The law requires that the death ocate has been signed by the attenct page 2 should be detached for us. Completed by Physician/	F	Part II. Other significant conditions	eontributing to death b	ut not resultin	g in the un	derlying cause give	en in Part I.			o use contribute to the	10
has bee								24a. Was		death?	psy findings available impletion of cause of
ficate ficate or, pa		05 Man and mad be seed to 1						1 □ Yes	2 12	yo 1 ☐ Yes	2 UNO
certificactor	1	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		100	Othe	26. Place of Dea				
er this gral d	2	7. Manner of Death	28a. Date of Inju	ent 2 ER	Outpatien b. Time of	1 3 DOA	4 W Nursing H	ome 5 ☐ Res 28d. Describe		6 ☐Other (Specification)	y)
th. : Afte s fune		1 Natural 5 ☐ Pending investigation		y, Year)	Injury	28c. Injur Work M 1 🗀	(? Yes 2 □ No		,	, ,	
tal or Attending Phys rs after death. al Director: After this i led in by the funeral dir Certification: To		3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injusting, etc.	ury - At home c. (Specify)	, farm, stre	et, factory, office		28f. Location City or To	(Street a wn, Sta	and Number or Rura ite)	I Route Number,
thin 24 hours the Funeral orthefeld filled		29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exam	nysician: To the best niner: On the basis o and manner st	f examination	dge, death and/or inv	occurred at the tir restigation, in my o	ne, date end place pinion, death occu	, and due to the rred at the time	e cause , date a	(s) and manner as s	tated. the cause(s)
ithin of the sample	2	29b. Signature and title of certifier	and mariner sta	ateu.		29c. License	e number		29d. D	Date signed (Month,	Dav, Year)
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		0. Name and address of person who	Amplified and	loeth (line on	n) /T 5	Drime)				10/09	
12	0	o mante and address of Derson Who	completed cause of d	eam (nem 23	a) (Type, F	nny .					
14	3	Richard Porter,	м.р. 211	N E	nirth	Street	Oakland	MD 21	550		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Richard Oct. J. Kamauf 23, 8:40 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing & Reh Frostburg, M Allegany

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 ★M 2 ☐ F Hours 215-20-6099 83 Director Jan 6 1926 Maryland Usual Residence of Decedent death with the Maryland 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, it w Wodical Experience. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11310 Upper Georges Crk SW U.S.A. 21532 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No Specify: ģ Specify: White 3
 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile Industry Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Emil Kamauf Millicent (Cooper) Kamauf ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21532 19a. Informant's Name/Relationship (Type. Print) Carol J. Blubaugh 11438 Upper Georges Crk Rd SW, Frostburg, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 28 09 Cumberland, MD Sunset Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service PA 21. Signature of Funeral Service License 1302 National Hwy., LaVale, MD 23a. Partil. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastal c 4 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Use to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.O. signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mn woweds 00055325 23,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Cumber land MD 21502 925 Bishop W 82. Registrar's Signature WONSOCK Walsh 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 34927 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2009 1:02A M Ruth Margaret Long October 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Home for Hospice Caroline Denton 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min Director 78 North Carolina 414-44-6746 August Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. death v Funeral 10741 Knife Box Rd. 21629 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔼 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 Specify: 3 Midowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Inc. M. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Slagle Nora Knippe ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Long/ 10741 Knife Box Road; Greensboro, Maryland 21639 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation Oct 12, 2009 Chester, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein, Funeral Home, PA tiple 23a. Part 1. Enter the disease, or complications that "aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list and in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-trar execu Due to (or as a consequence of): Records, P.O. Box 68760, attending physician requires that the death certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
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To the Funeral Director: A
completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 063063 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) Co, MI OCTOBER 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEPHEN RUALO, MD 609 DAFFIN LANE DENTON, MD 21629 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2009 Registrar

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			For State Registrar	State o	f Marylan	_	artment of ctificate of				iene eg. No. 20	09	3492
			1. Decedent's Name (First, Middle	e, Last)						ate of Deat			3. Time of Death
	Physici /Medic		Pauline	Edith I	Lewis				Oc.	tobei	$c \stackrel{\text{Day}}{4}, 20$	09	7:48 PM
-	Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town,	or Location	of Death		4c. County of	Death	
لبر			24903 Woods	Drive			Dento	n			Carol	ine	
	Funeral		Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yea Months Days		24 Hrs. 8. D Min. (4	ate of Birth Month, Day, 0 • 28	Year)	Carre	place (State or Foreign
п	Director		224483352	1□ M 2∏ F	104	Yrs.	monaro Day	1,00.0	Fel	b. 28	3,71905		wa
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation			_		1	0d. Inside City Limits
21215-0036	faryla f sho	ō	MD Caro	line	Dent								1 □ Yes 2X No
	28a-	ect Ct	10e. Street and Number				10f. Zip Code			11	0g. Citizen of Wh	at Cour	
	3a or	Ξ Ω	24903 Wood	ds Drive			216				ISA		,.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 11 Medical Experience related any once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	Armed Fo	ve		Vas Decedent of f Yes, specify Cu	ban, Mexicar	n, Puerto Ricar	es or No- ı, etc.)	14. Race Black, Cauca Specify:	White,	etc.
5-0	72 ho	etec	15. Deceden (Specify only highes	s Education		(Give	lent's Usual Occ kind of work don	e durina mos	t of working		16b. Kind of Busi	ness/In	dustry
121	vithin ne. han "	μp	Elementary/Secondary (0-12)	College (1	I-4or 5+)	Teac	00 NOT use retii	red)			Educat	ion	
	iled v Hygie ther t		17. Father's Name (First, Middle,			reac		18 Moths	ar's Name /Firs		Maiden Surname)		
Maryland	d be tental	9 Be	Garfield	В.	Trind	10		10. 11100110	Edith		araon ournamo,		tchell
Ĭ	shouls nd M mari	၉	19a. Informant's Name/Relations		TITIIQ	T	a Address (Stree	et and Numb			City or Town, S		
	alth a 27 is		Michael H.		son						, MD 2		
Baltimore,	Pages 1 a ment of He. ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (S)		State 20b. P	Place of Dispo emetery, cren pitol	sition (Name of natory or other pi Crema	ace) tory	Date 10/05		20c. Location - C Dover,	•	wn, State
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service	icers	٧	M	Name and Add	unera	1 Home	, PA	12 S.	2n	d St.
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that c	aused the death	h. Donotent	er the mode of d	ying, such as	cardiac or res	piratory arre	est,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	-a 71		5 AR					VAICULA	RA	Onset and Death
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
	ficate be executed physician and s the burial-transit							_					
60,	be excian a		resulting in death) Last	Due to (or as a consequ	uence of):							
68760,	physi the t	dical		d									
P.O. Box 6	Attending Physician: The law requires that the death certificate has been signed by the attending isctor. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown	1 Live L	come of pregna birth 2 Fetal nant at time of d	Ideath 3	Ectopic pregnal Other (specify)				23d. Date Mont		ery Day Year
	signed by	by Ph	A at it. Other significant conditions contributing to death but not resulting in the underlying ca								acco use contribute to the cause of death?		
ord	w requir been si should I	ted	14 4 1 CR TONS							1 ☐ Ye	s 2 No 3	☐ Prol	pably 4 ☐ Unknown
Vital Records,	ician: The law certificate has b ector, page 2 sh	Completed	HYPOTHYB	مري رودو						24a. Was ar autops perforn ∐Yes 2	y pri ned2 de	or to co ath?	psy findings available mpletion of cause of 2 No
₹	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			0	thor:	of Death (Che				
	Phys r this ral dir	5	1 ☐ Yes 2 Mo	28a. Date	Inpatient 2 of Injury	28b. Time of	I 3 L DOA	4 🗆 NI			ence 6 Other		(y)
o	nding Phy th. : After thi : funeral o	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investig	g (Moni	th, Day, Year)	Injury	28c. Inj W	ork? □Yes 2 □		Seconde no	injury occurred	•	
Division of	I or Attend after death Director:	Certification: To	3 Suicide 6 Could r	ot bo	of Injury - At ho ng, etc. <i>(Specif</i>)	ome, farm, stre	eet, factory, office		28f. L	ocation (St	reet and Number n, State)	or Rura	al Route Number,
Ω	oital ours af		00.0.17						J.				
	To the Hospital or A within 24 hours after within 24 hours after To the Funeral Director completely filled in b	Medical	29a. Certifler Certifyin (Check only one)	g Physician: To the E xaminer : On the b and mani	best of my kno asis of examina ner stated.	wledge, death tion and/or in	occurred at the estigation, in my	time, date ar opinion, dea	nd place, and o ath occurred at	the time, di	ause(s) and man ate and place, ar	ner as s id due t	stated. o the cause(s)
	To the complete compl	ž	29b. Signature and title of certifier	> 0			29c. Lice	nse number		2	9d. Date signed		
			young				Pe	90 47.	5-69		10/3	10	9
			30. Name and address of person	who completed caus	se of death (Item	1 23a) (Type,	Print)						
			VANUS EACH	MAD	(09 W	ACTIN		ONTO	M W	D 5	1629		
	Sta Registra		31. Date filed (Month, Day, Year) OCT 0 6	2000	egistrar's Signa	A A	add						
			301 00			-							

DHMH 17 Rev 1/2001

W 10

State of Maryland / Department of Health and Mental Hygieneo o o

			1 - For State Registrar	State of Mis	Ce	rtificate of	Death		eg. No.	34929	
	Physici	on	1. Decedent's Name (First, Middle	e, Last)				2. Date of Death Month		3. Time of Death	
-	/Medic		Marion	Ε.		Lindel1		October	14, 2009	7:00 A M	
	Examir	er	4a. Facility Name (If not institution 6575 Glendale	-		4b. City, Town, c	or Location of Death		4c. County of Death Charles		
	Funeral	-	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign	
	Director		045-36-1710	1□M 2☐F	97 Yrs.	Months Days	Hours Min.	May 4,	1912 Cou	onnecticut	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	Maryi f sho	tor		arles	La Pla					1 □Yes 2X No	
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	ntry?	
	23a c	ralD	6575 Glendale	Place		20	646		USA		
	items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 📉 N	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,		
936	I within 72 hours after death with the Maryland glene. I than "natural", or items 23a or 28a-f show the Marylan Evaning must be notified at	by	1 ☐ Never Married 2 ☐ Marr 3 🕅 Widowed 4 ☐ Divorced	ied Tyes 2 <u>M</u> r If Yes, Give Year or Dates:	NO	1 □Yes 2X No	Specify:		Specify: W	hite	
2-0	72 hou	Completed	15. Decedent (Specify only highes	i's Education	16a. Dece	edent's Usual Occup	pation	ing 1	16b. Kind of Business/In	dustry	
121	within iene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.		during most of work d)	ang	••		
d 2	al Hygie other t vent, th		17. Father's Name (First, Middle,			Homemak		e (First, Middle, M	Home		
an	should be 1 nd Mental marked o matic eve	To Be	Fred Safford					May Saf:	,		
ary	and and sum	-	19a. Informant's Name/Relations	nip (Type, Print)					City or Town, State, Zij	c Code)	
Σ,	1 and 2 Health em 27 i		Barbara Shivel	y/Daughter			e Place,				
JOLE	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation		20b. Place of Disponentery, cre				20c. Location - City or To		
Baltimore, Maryland 21215-0036	# 보면는		4 □ Donation 5 □ Other (S) 21. Signatura of Funeral Service		I COOK		Crem. 10		Charlotte H	all,MD	
ñ	permi Depa Impo any ir once.		1 / quis C.	Esal			ECHOLS FU		ME,P.A. ata,MD 206	1.6	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
J.	Physician /Medical Examiner		Immediate Cause (Final disease or condition ARTERIOSCLEADITE CARDINOVASCULAR DISCASE and Death								
and the same			resulting in death)	Due to (or as	a consequence of):						
		ēr	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
, 0	e exe vian ar urial-tı		resulting in death) Last	Due to (or as	a consequence of):						
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d							
		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of deliv	TOP!	
. Box	death cei e attendir d for use	Physician/I	in the past 12 months?	4 ☐ Pregnant at		☐ Ectopic pregnand ☐ Other <i>(specify)</i>	СУ		Month	Day Year	
P.O.	ires that the de signed by the I be detached I	hys	9 ☐ Unknown	9 🗆 Unknown							
JS,	ires th signed	þ	Part II. Other significant condition	ns contributing to death bu	ut not resulting in the u	inderlying cause giv	ren in Part I.		acco use contribute to t		
Ö	w requir been si should b	eted	-					1 ☐ Ye		bably 4 Unknown	
Be	he law e has ge 2 s	Completed						24a. Was an autopsy perform	y prior to co	opsy findings available ompletion of cause of	
ta	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical				26. Place of Deat	perform 1 □ Yes 2		2 □ No	
	ysici	To B	examiner? 1 ∐ Yes 2 ∐XNo	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DOA Oth	or.		nce 6 ☐Other (Speci	fy)	
Division of Vital Records,	Attending Physician: The law requires that the rdeath. rdeath. ector: After this certificate has been signed by the tuneral director, page 2 should be detached.	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	ry 28b. Time o	Wor	ry at k?	28d. Describe how	w injury occurred		
isio	death death stor: / the f	icati	2 Accident investig	ot ha	ury - At home, farm, etc		Yes 2□No	29f Location /Ct-	and and Musel and a Dist	-/ Davida Niverban	
<u>></u>	p # in in in	Certification:	4 ☐ Homicide determi	building, etc	ury - At home, farm, sti c. (Specify)	cet, factory, office		City or Town,	eet and Number or Run , State)	ai noute ivurnuei,	
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical I	g Physician: To the best of Examiner: On the basis of	of my knowledge, deat	th occurred at the ti	me, date and place,	and due to the ca	ause(s) and manner as	stated.	
	the H thin 24 the F mplete	Medical	one)	and manner sta	ited.						
	5 ¥ € 0		29b. Signature and title of certifier			29c Licens	I SCY	29	od. Date signed (Month,	15.7009	
		-	30. Name and address of person v	who completed cause of de	eath (Item 23a) (Type.	Print)	7	- 0	1000	1 1 2001	
1	DB2		Y, WISOTSK	M.D.	12070	OLD L	ine Le	aver u	od. Date signed (Month, XTOBER VALOORF, (Vol. 2060.	
	Sta Registra	i.e	31. Date filed (Month, Day, Year) OCT 1	6 2009 32. Registra	ar's Signature	hukel					
	riegistii	.1	001 7	O COOD DEATH	m 10. 19						

			1 - State of Maryland / Department of Health an Certificate of Death	nd Mental Hy	glene Reg. No. 2009	34930
	Physici	ın	1. Decedent's Name (First, Middle, Last) Anna Mae Loar	2. Date of De Month	eath Day Year	3. Time of Death 7:00 A M
no.	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D Lonaconing	Oct Death	4c. County of Deat Allegany	h
	Funeral Director		212-24-1161 Yrs.	Min. 8. Date of Bir	th 9. Bird 24, Year) 9. Bird Co 20, 1915 Mar	hplace (State or Foreign nuntry) Yland
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Examiner must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Lonaconing			10d. Inside City Limits 1 [™] Yes 2 □ No
		Funeral Director	10e. Street and Number 32 Watercliff St. 10f. Zip Code 21539		10g. Citizen of What Co United Stat	
9036	ours after dea ral", or items Exercine com	d by Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No n? (Specify Yes or No Puerto Rican, etc.)	_		
Baltimore, Maryland 21215-0036	within 72 ho jiene. r than "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Seamstress	f working	16b. Kind of Business/ Sewing	Industry
land 2	uld be filed Mental Hyg irked other	To Be C		Name (First, Middle, sdemona E	, Maiden Surname)	
, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Linda Gordon/ niece 19b. Mailing Address (Street and Number of 19811 Brant Hollow II)			
imore			20a. Method of Disposition 1 ☎ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Hill Cemetery 20	0/13/ 009	20c. Location - City or Lonaconing	
Balt	permit, Depart Import any Inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 111 Church St, 1	Boal Fune Westernpor		21562
1	Physician /Medical Examiner	irrest,	Approximate Interval Between Onset and Death			
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, that y, teaching to thirticiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):			
.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☑ No 9 ☐ Unknown		23d. Date of de Month	ivery Day Year
rds, P.			Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to Yes 2 No 3 P	the cause of death?
al Records,		Completed by		24a. Was auto perfo 1 ∐Yes	psy prior to death?	itopsy findings available completion of cause of 2 □ No
of Vital	hyslcian: The la his certificate ha I director, page 2	To Be	examiner?	Death (Check only only only only only only only only	one) dence 6 □Other <i>(Spe</i>	cify)
Division o	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be		how injury occurred	
Div	nital or A		4 Homicide determined building, etc. (Specify)	City or To		
	the Hosp hin 24 hoi the Fune apletely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and process of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the occurred at the time,	date and place, and due	e to the cause(s)
	To To	2	29b. Signature and title-of certifier 29c. License number 20c. License number 29c. 20c. License number	669	29d. Date signed (Mont	n, Day, Year)
		6	30. Name and address of person who combeted cause of death (Item 23a) (Type, Print) Cynthia Stafford, 925 Bishop Walsh Dr., Cumberland	, MD 2150	02	
	Sta Registra		31. Date filed (Month PG) [Year 3 2009 32. Registrar's Signature			

		1 - State of Maryland State of Maryland State	d / Depa <i>Cer</i>	artment of H <i>rtificate of L</i>	lealth and M D <i>eath</i>	lental Hyg	ene 2009	34931
Dhamis		1. Decedent's Name (First, Middle, Last)				2. Date of Deat	h Day Year	3. Time of Death
Physici /Medi		Mary E. Leslie	October	14 2009				
Examir	ner	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
Funeral		Golden Living Center 5. Social Security Number 6. Sex 7. Age (In yrs. I)	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
Director		214-14-9621 1□ M 2∏ F 88	Yrs.	Months Days	Hours Will.	Aug. 12	, 1921 M	laryland
land ow			y, Town or Loc					10d. Inside City Limits
Mary a-f sh	ctor	MD Carroll West	tminste	er				1 □Yes 2 □No
iff the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	ountry?
sath w	eral	103 W. Sunshine Way	C 110 V	21157	iononio Origina /Cn	ooifu Voo or No	U.S.A.	origan Indian
perilliore, Marylania 414.15-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middel Evaninar must be routified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		i ⊠Yes 2 MNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	te, etc.
72 hc	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done o	ation during most of works l)	ng	16b. Kind of Business	/Industry
within ene,	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Superviso			C&P Tele	phone
il Hygi	Be C	17. Father's Name (First, Middle, Last)	L		18. Mother's Name	(First, Middle, N	Maiden Surname)	
Vidio be Menta arked atic ev	10 B	John J. Dixon, Sr.			Edna M	Sheffe	r	
and 2 sho salth and 27 Is me er traume		19a. Informant's Name/Relationship (Type. Print) John J. Leslie - Son	19b. Mailin 25 W	g Address (Street & Oodcrest	and Number or Run Circle, I	al Route Number Littlest	, City or Town, State, Own , PA 17	Zip Code) 1340
es 1 and Telement of Herman		20a. Method of Disposition 20b. P 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	lace of Disposemetery, crem	sition (Name of natory or other place	e) [Date	20c. Location - City or	Town, State
t. Pag tment tant:		4 □ Donation 5 □ Other (Specify) Carr					Hampstead,	_
Department Department		21. Signature of Funeral Service Licenses	22	Pritts F	uneral Ho	ome & Cha	apel, P.A.	
		23a. Part 1. Enter the disease, or complications that caused the death	n. Do not ente	412 Wash er the mode of dyin	ington Rog, such as cardiac	or respiratory arre	minster, M est,	D 21157 Approximate Interval Between
Physician		shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition	an	te a	newy	m		Onset and Death
/Medical Examiner		resulting in death) Due to (or, s a consequ	uence of):	. 10	-	1		
LAMIIIICI	Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ	rence of	tic Va	sentin	Dise	un	soy
ruted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	reed	an	_			8 Sun
eath certificate be executed attending physician and for use as the burlal-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of the cons	uence of):	0				007
cate b physic the bu	edical	d						
certiff ding	/Me	IF FEMALE: 23b. Wes decedent present: 23c. If yes, outcome of pregna	ncy				23d. Date of de	livery
e death the atte	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)	4		Month	Day Year
ires that the de signed by the a		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resu	alting in the un	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?
quires n sign ald be	d by					1 □ Ye	es 2⊠No 3⊟F	Probably 4 ☐ Unknown
e law requir	Completed					24a. Was as	n 24b. Were a	utopsy findings available completion of cause of
The The sate has page	E O					perform	med? death?	
Physician: The la Physician: The la rthis certificate ha ral director, page 2	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of Deat			
Phys	.T	27. Manger of Death 28a. Date of Injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury Work	4 Nursing Ho		ence 6 Other (Spensor injury occurred	ecify)
ath, r: After	Certification:	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		? Yes 2 □ No			
5 5 5 ± 0	iįį	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At no building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location <i>(St</i> City or Town	reet and Number or F n, State)	Rural Route Number,
al or Ai safter of Direction by	둳							
Hospital or Attending Physician: The law requires that the death certificate be executed no 24 hours after death. 1.24 hours after death. 1.25 hours after this certificate has been signed by the attending physician and lettely filled in by the funeral director, page 2 should be detached for use as the burlal-transit.		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner: On the basis of examinat and manner stated.						
To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A completely filled in by the tr	Medical Cert	(Check only 2 Medical Examiner: On the basis of examinal			pinion, death occur	red at the time, d		e to the cause(s)
To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by		(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier W. M.	tion and/or inv	29c. License	pinion, death occur e number	red at the time, d	ate and place, and du	e to the cause(s)
To the Hospital or Al within 24 hours after to the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier W. M.	tion and/or inv	29c. License	pinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 20.55 PM **Physician** 2009 IRGINIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 8. Date of Birth (Month, Day, Year) April 23,1919 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🖺 F Maryland 217-03-9386 90 April Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examiner must be notified at 1 ☐ Yes 2 No New Windsor Carroll Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21776 1706 Dennings Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ∐Yes 2**√√N**o If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2XXXNo Specify Specify: White þ 3XXWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Clay Maggie Harry Reiblich ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1706 Dennins Road New Windsor, MD Patricia Edel Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olive Ch.Cemetery Oct.19,2009 Randallstown, MD Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 21. Sign of Funeral Service License Approximate Interval Between Onset and Death 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc or heart failure. List only one cause on each line. mediate Cause (Final sease r condition ing in death) Physician Traumatic BRAIN INJURY /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): TERTIFICATION APPROVED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed Small Right
Due to (or as a consequence of): sician and burial-trans Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 👿 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 No 1 ☐ Yes 2 MNo 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death After 10/12/09/ U.N.K.N.C.W.M. 1E 28e. lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No Fall 24 hours after death. 2 X Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1700 Demogs Road New Wind 3 Suicide determined 4 ☐ Homicide NEW WINCKDEIM Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) соmpletely the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SGREENE S+ Baltimore, William (22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 34933 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Month **Physician** 1:58PM ROBERT **JEROME** LEE 13, 2009 October 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's 737 Capitol Heights Boulevard Capitol Heights 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1954 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 🕅 M 2 🗆 F 577-72-2303 55 Yrs. Washington, DC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show nd 2 should be filed within 72 hours after death with the Maryla th and Mantal Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show " renumatic event, " I waster Event in count on notified a 1 XYes 2 No Director Maryland | Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 737 Capitol Heights Blvd. 20743 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 x Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Lee Myrtle Smith John Mary ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tennille Lee Royal (Daughter) 322 34th St., NE. Washington, DC 20019 item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 10/21/2009 Suitland, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature d Funeral Service Licensee 4001 Benning Rd., NE, Washington, DC 20019 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** OBSTRUCTIVE SLEEP APNEA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KIDNEY DISEASE CHRONIC Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed HYPERTENSION and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burlal-P.O. Box 68760. DIABETES MELLITUS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a I be detached f 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed After this certificate funeral director, pag 1 ☐Yes 2 ☐ No 1 □Yes 2 No ospital or Attending Physicien: hours after death. 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☑ Natural 2 ☐ Accident within 24 hours area
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cer 29c. License number 29d. Dale signed (Nonth, Day, Year) (Item 23a) (Type, Print) 30. Name and address of persor of de 106 Trying St. M.D Aroti Hedge, N.W. Suite 208 Washington. DC 20010-2927 31. Date filed (Month. Day. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34934 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Raymond R. Lepley 30 /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death **Examiner** HIEGAN mberlan Addock If Under 24 Hrs Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number **Funeral** Year) 89 215-18-8919 Director Sept. 1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be retiffed at Director 1 ☐ Yes 2 No PA Somerset Southampton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1137 Shirley's Hollow Rd 15565 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 K No ۵ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farm Feed Sales 8 Self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Lepley Annie (Delbrook) Lepley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Lease 14804 Main St., Hydman, PA 15545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem Park Oct 26 09 LaVale, MD 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Lice 0 1302 National Hwy., LaVale, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** DAYS /Medical Examiner ant Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physiclan and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide

P.O. Box 68760, Records, Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1) 4205

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Medical

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

() 2009

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State of Maryland / Department of Health and Mental Hygiene 2009 34935 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Dav 0750 A M Louis Thomas Larsen October 0 23 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 West Parkway E1kton Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1X M 2□ F FEB 1, 1924 85 Director 146-14-7568 New Jersev Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 102 West Parkway 21921 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🚻 No Specify: Specify: þ 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 721 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Mechanical Engineer Mechanical Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis E. Larsen Marie Wayson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stands of Health ar Important: If item 27 is any injury or other trauonce. Jeanne Costanza/Sister 3 Candy Lane, Oneonta, NY 13820 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Aviat Cemetery 29, 2009 Childs, MD 22. Name and Address of Facility
Hicks Home for Funerals, 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton. 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as the attending use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy jo Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. detached 9☐Unknown 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed been (24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ◯ No 24a. Was an has page 2 autonsy perform certificate 1□ Yes 2 No or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 00 Hospital: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: within 24 hours after death. To the Funeral Director: After Division (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ame and address of person who completed cause of death (Item 23a) (Type Print) loria 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Marylar		artment <i>rtificate</i>					gien e Reg. No		34936	
	Physici	an	Decedent's Name (First, Middle	a, Last)						1	Date of De. Month	Day	y Year	3. Time of Death	
	/Medic		Jacquelyn Ann								October 13 200			8:50 A M	
	Examin	er	4a. Facility Name (If not institution				4b. City, T			of Death					
			Corsica Hill N				Centi		11e	24 Ure 1			een Ann		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	67 Yrs.		Days	Hours	Min.	B. Date of Bird (Month, Da	y, Year)	9. Birt Co	hplace (State or Foreign untry)	
	Director		217-38-7370 Usual Residence of Decedent			07	1			Ma	ay 28,	1942	кеп	tucky	
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits	
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	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number				10f. Zip (10g. Cit	izen of What Co	untry?	
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	d within 72 hours after deeth with the Maryland liene. r than "natural", or itema 23a or 28e-f show The Medical Exantrar must be redified at	Funeral	11. Marital Status	12. Was De	12. Was Decedent Ever in U.S. Armed Forces?			ent of Hi	spanic Ori	igin? (Spec	ify Yes or No ican, etc.))-	14. Race - Ame Black, Whit		
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9500-612	nat	Completed	15. Deceden (Specify only highes	t's Education of grade completed)	16a. Dece	dent's Usual kind of work DO NOT use	Occupa done o	ation <i>furing</i> mos	t of working	9	16b. K	ind of Business	Industry	
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<u></u>	should ind Meni	-	19a, Informant's Name/Relations			19b. Maili	ng Address				al Route Number, City or Town, Sta			Zip Code)	
Mar	es 1 and 2 should of Heelth and Me litem 27 is mark r other traumatio		Wayne Meade, J	r. / so	on	3959	Sea Br	ream	Cou	rt. No	orth B	each	, Maryl	and 20714	
saitimore,	S 1 a f Hee itam othe		20a. Method of Disposition		20b. F	Place of Disponentery, cre-				Da	-		c. Location - City or Town, State		
Ē	Pege ent o nt: if ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State					ct.14	2009	Ches	ester, Maryland		
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ñ	Page a		1 Street (Fle	ul		Teegle	e an Sun	d He.	lienb Ave	ein Fu Green	nera sbor	o, Mary	1and 21639	
п			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deal									Approximate Interval Between	
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Š	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):											
g/90	ate b hysic the bi	dlcai		d											
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X D	death certifi e ettending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 ☐ Feta	al death 3	Ectopic pre						23d. Date of de Month	livery Day Year	
	the de y the e	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unk	gnant at time of one of the community of	death 5L	Other (spe	cify)							
7.	uires that the death certifi signed by the ettending d be detached for use as		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderwing ca	USA CIVA	an in Part I		23e Did t	nhacco	use contribute to	the cause of death?	
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ě	e law	ш						-			24a. Was			utopsy findings available completion of cause of	
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VIII	Physician: The law this certificete hes tral director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:		2500		Othe			(Check only o				
ō	Phy this rald	!- :	1 Yes 2 No	28a. Date		28b. Time o		A	4 ZTN(e 5∐ Resi Bd. Describe		6 Other (Spe	icify)	
0	ding Phi th. After thi funeral	tion	1 datural 5 ☐ Pendin 2 ☐ Accident investion	g (Mo	nth, Day Year)	Injury	м	C. Injury Work	ດ?ົ Yes 2.∐				,		
UNISION	Atten deal actor	fica	3 Suicide 6 Could	not be 28e. Place	e of Injury - At h		reet, factory,							ural Route Number,	
5	efte Dira	Certification:	4 Homicide determ	build	ding, etc. (Speci	fy)					City or To	wn, State	9)		
	papita hours nere y fille		29a. Certifier factifying	g Physician: To th	ne best of my kno	owledge, deat	h occurred a	it the tim	ne, date ar	nd place, ar	nd due to the	cause(s) and manner a	s stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical one)	Examinar: On the	basis of examina nner stated.	ation and/or in	vestigation,	in my op	oinion, dea	ath accurred	d at the time,	date an	d place, and due	e to the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifie				29c.		number				ate signed (Mont		
			> 7 () X	mm?	>			D	379	36		13	61911	00 9	
			30. Name and address of person	who completed cau	use of death (Iter	m 23a) (Type,	Print)	ı t	1		. 0	,	61419 M 2	1	
			16 1 20	run	2/17	YD	DO	rut	17/	ive	Cho,	ik.	M 91	619	
-	Sta	•	31. Date filed (Month, Day, Yeld)	32.	Registrar's Signa	ature								/	

State

Registrar

OCT 16 2009

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar Certificate of Death Reg. N2 34937
	Dhysicia	20	Decedent's Name (First, Middle, Last) 2. Date of Death Anoth One of Death Anoth One of Death
	Physicia /Medic		Billy J. Morris 10/09/2009 54 1 M
	Examin	er	a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ADIVERSITY Specialty Hospital Baltimore Baltimore
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Ш	Director		413-48-4330 76 778 09/17/1933 Tennessee
	rland ow		Sual Residence of Decedent
	e Mary a-f sh tified	ctor	DE Kent Felton 1 □Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Director	0e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eath v	Funeral	83 Jarrells Road 19943 USA 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
٥	after d or iten niner		Armed Forces? If Yes, specify Cuban, Mexican, Puèrfo Rican, etc.) 1 □ Never Married 2 ☒ Married 1 ☑ Yes 2 □ No
200	ural", c	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: White
<u> </u>	in 72 l 1 "nat ledica	olete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working (life. DO NOT use retired)
7	filed withi Hygiene. other than ent, the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Classroom Assistant Education
B	be file Ital Hy id oth event	Be	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Š	2 should be and Mental is marked o aumatic eve	၉	Lee Morris Laura (Sansom) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u> </u>	and 2 s lealth ar m 27 is her trau		Priscilla G. Morris, wife 83 Jarrells Road, Felton, DE 19943
ore,			0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
	F F F F		4 Donation 5 Other (Specify) Hollywood Cemetery 10/14/2009 Harrington, DE
р О	permit. Departr Imports any Inju		22. Name and Address of Facility 19952 Melvin FH, 15522 S. DuPont Hwy., Harrington, DE
r			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between
	Physician		immediate Cause (Final disease or condition Resource Failure 7 to emphysical Smanth
	/Medical Examiner		Due to (or as a consequence of):
Ĺ		Jer	Sequentially list conditions, tany, leading to immediate pause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):
	xecuted and al-transit	xaminer	hat initiated events . Inoperable Inoració Aortic Aneurysin Smug
oo,	be exectan a	ш	Due to (or as a consequence of): Atrial Flutter 8 May 4
00/00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	sician/Medical	d. AITIUTTUHU
Z D D	th cert	an/M	F FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery
5	ne dear the att hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify)
ŗ.	that the	/ Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
necords,	equires en sign	ed by	Dementia Delerium, Failure to Wean from 12 Yes 2 No 3 Probably 4 Unknown
) ()	law re as bee 2 sho	Completed	Yentilator 24a. Was an autopsy prior to completion of cause of
	r: The icate h ; page		performed? death? 1□ Yes 2□ No 1 □ Yes 2□ No
VILA	siclar s certifi	o Be	15. Was case referred to medical examiner? 1 Yes 2 The solution of the solutio
5	ig Ph) ter this	n: To	17. Manner of Death 1
UNISION	tendir eath. tor: Af the fu	catio	2 Accident investigation M 1 Yes 2 No
2	l or At affer d Direc J in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ H
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burs after death. within 24 burss after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical C	29a. Certifier (Check only one) 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the comple	Mec	29c. License number 29d. Date signed (Month, Day, Year)
•			Mistelle 7, MD 00057218 10/9/09
			10. Name and address of person who completed cause of death (Nem 23a) (Type, Print) GERCH CLEW TEFFERM MP 601 South Charles St. Baltimore, Mp 21330
	Sta		Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar PH MH 17 Rev 1/2001 30. Name and address of person.

Get Cichew Tefferra
31. Date filed (Month, Day, Year)

OCT 16 2009

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State of Maryland Department of Health and Mental Hygiene 2009

Registrar AMENDED #1 PER FH 10/9/09 Certificate of Death COHD AS Reg. No. 34938 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Carla Ray McNeal Carla Rae McNeal OCT. 07 2009 0930 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Queen Anne's Centreville Queen Anne's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Year) 1 ☐ M 2 😰 F 35 Yrs. 216-15-1256 Director 28. 1974 Maryland Aug. Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Preston Director MD Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5941 Nagel Road 21655 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or iten any filury or other traumatic event, the Medical Examina Yes 2√∑No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caroline Center Cert. of Completion Constract Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Woodrow McNeal Alcinda Jayne Collier ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl W. McNeal/Father 5941 Nagel Road, Preston, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2x☐remation 3 ☐ Removal from State East. Shore Veterans 10/13/09 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Set and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 54K **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed Exami burial-trar and Due to (or as a consequence of): ng physician as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Yea 4☐Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 2 No 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P MOSPICE 28a. Date of Injury (Month, Day Year) after death.
I Director: After to in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide or

State Registrar

within 24 hours a

2

Medical

29a. Certifier

29b. Signature

30. Name and address

31. Date filed (Month, Day, Year)

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and manner stated.

DHMH 17 Rev 1/2001

1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County Clinton P.G. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) November 28,1935 Maryland 1 □ M 2X F Months Days Hours Min. Director 218-34-6047 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County with the Maryland ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 Yes 2 No Prince George's Maryland Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17111 Magruders Ferry Rd. 20613 USA and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 X Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)
Clerk Prince George's d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ William Richards Dora Canter 19b. Mailing Address (Street and Number cr Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14871 Grace Keller Drive, Waldorf, MD 20601 f Health item 27 Glenn Myers/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 2009 Waldorf, MD Trinity Memorial Gardens 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20624 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the attending physician and ned for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a cons resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) Month Dav Year Pregnant at time of death this certificate has been signed by the a ral director, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျှ 1 🗌 Yes 2 X No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After the in by the funera injury Natural Accident work? 1 Yes 2 No 5 Pending М Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies are Legible.
Amend Ttems 25,26,29a per pllys Ensure All Copies are Legible.
State of Maryland / Department of Health and Mental Hygien 2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Рм 3:00 Mary Helen Morgan October 18, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26886 N. Sandgates Road St. Mary's Mechanicsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 86 Yrs Director 219-84-9200 August 13, 1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2X No Directo Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 20659 USA 26886 N. Sandgates Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of Be 27 is marked of traumatic even Joseph Ashby Quade Nellie Eleanor Farrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce, 26559 Tin Top School Road Cindy Popielarcheck / Daughter Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens Leonardtown, Maryland 2009 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 use of Funeral Service Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HTHEROSCIPLATIC CARDIOJASCULAR **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans Due to (or as a consequence of Box 68760, physician the burial Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Vital 2/ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. Certification: 5 Pending investigation Division 1 Natural 2 Accident Injury after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) License number 29b. Signature ar of certif 29d. Date signed (Month, Day, Year) 10-20-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orest Bartoszyk, P.O. Box 2101 M.D. Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 1 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** FRANCES PRICE MATTHEWS tober 14,2009 :10 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Social Security Number 6. Sex 7. Age (In vrs. last of thickness) Wicomica isburc 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 X F Months Hours MARYLAND Director 218-16-9660 OCT. 13. 1912 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1XYes 2 □ No Director event, the Medical Examiner must be notified MD WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 21804 30439 BENNETT ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married o, 21215-0036 1 ☐ Yes 2 🕱 No Specify. WHITE δ 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, It alone. _n_ CLOTHING GARMENT MAKER Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JARRETT PRICE MARY FORD ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELLA IMAN/ DAUGHTER 30439 BENNETT ROAD, SALISBURY, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔣 Burial 2 □ Cremation 3 □ Removal from State CHESTERFIELD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 10-16-2009 CENTREVILLE, MD 21. Signature of Fune of Fervice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Cause (Fine) Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sau nitely list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed es burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ New 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 📑 No 1 □ Yes 2 □ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 □Yes 2 Accident investigation 2 ∏ No. 24 hours after deat filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins

Year)

31. Date filed (Month, Day, Ye

5, MD, 200 32. Registrar's Signature

		ľ	For State Registrar		viaryiano / L		tificate of I			Reg. No	2003	
н	Physici	an	1. Decedent's Name (First, Middle Edmund Joseph						2. Date of Dea	Da	Year 6, 2009	3. Time of Death 12:40 a ^M
1	/Medic		4a. Facility Name (If not institutio				4b. City. Town, or	Location of Death			. County of Death	J
	Examir	ier	Montgomery Hospice-Casey House Rockville									tgomery
	Funeral Director		5. Social Security Number 168-34-4699	6. Sex 1 M 2 □ F	Age (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da July 3,	y, Year)	Cou	place (State or Foreign intry) sylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside City Limits
	Maryla f sho	ō		tgomery	Kens							1 □Yes 2 ■No
	the 1	Director	10e. Street and Number	cgomery	Rens	sing	10f. Zip Code			10g. Ci	itizen of What Cou	intry?
	h with	a D	9624 West Be	exhill Driv	е		20895			US.	A	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evan. For court be realth of a	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	If Yes, Give	s?	1	√as Decedent of H Yes, specify Cuba □Yes 2 🛣 No	Ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		14. Race - Amer Black, White,	etc.
9	2 hour	Completed by	15. Deceder	nt's Education		. Decede	ent's Usual Occup	ation		16b. K	Whi Kind of Business/fi	
215	hin 7% e. an "na	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4d	or 5+)	(Give k life. D	aind of work done on the contract of the contr	during most of work i)	king			
2	filed wit Hygien other the	Son		5+		rpo	rate Dir					re Policy
nd	be file tal H d oth even	Be	17. Father's Name (First, Middle,	ŕ				18. Mother's Nam			,	
<u></u>	2 should be find and Mental His marked of aumatic even	유	Edmund Frank		T				ys Mae S			
Maryland	d 2 st th an 7 is n traun		19a. Informant's Name/Relations Mary Kathleen					and Number or Ru exhill Di				
	s 1 and 2 of Health item 27 is rother tra		20a. Method of Disposition	DIOGGWACC			ition (Name of atory or other place		Date		ocation - City or T	
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or of		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)		oli	tan Crem	atory 2	009			a, Virginia
Ba	Department of the position of		1 (inchew)	Alole		5	00 Unive		/d. W.,	Sil	ome Inc. ver Spri	ng, MD 2090
			23a. Part 1. Enter the disease, of shock, or heart failure. List	r col plications that cause on each	sed the death. Do r h line.	not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
- 19	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ui	tatic Esc	_	geal Can	cer				
-	Examiner		,	Due to (or	as a consequence	of):						
		ē	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury	b Due to (or	as a consequence of	of):						
,	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	S .								
o,	e exe ian ar irial-ti	Ä	resulting in death) Last Due to (or as a consequence of):									
68760,	tificate be executed ig physician and as the burial-transit	ledical		d								
	± Sc a		IF FEMALE:	000 16 100 01400								
.O. Box	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2□Fetal death nt at time of death		Ectopic pregnanc Other (specify) _	у			23d. Date of deli Month	very Day Year
rds, P.	quires that n signed b ıld be deta	þ	Part II. Other significant conditi	ons contributing to deat	h but not resulting in	n the un	derlying cause giv	en in Part I.				the cause of death?
Records,	The law requi	Completed									prior to c death?	topsy findings available ompletion of cause of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?					26. Place of Dea				
of V	d is is	2	1 Yes 2X No		atient 2 ☐ ER/Ou	utpatient		4 L Nursing n	ome 5 ☐ Resid	dence	6 XOther (Spec	Hospice
n C	ng ffe	ion:	27. Manner of Death 1 ✓ Natural 5 ☐ Pendir	9		Time of Injury	28c. Injur Worl	ί? 	28d. Describe I	now inju	iry occurred	
Sic	Attending in death. ector: After by the fune	icati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not he	Inium. At harma facility			Yes 2□No	006 Leastine (
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	4 ☐ Homicide determ	nined building,	Injury - At home, far etc. <i>(Specify)</i>	irm, sire	et, ractory, office		City or Tov	vn, Stat	nd Number or Ru le)	rai Houte ivumber,
	Hospi 4 hour Funer tely fill	Medical C	29a. Certifier (Check only one) Check only one)	ng Physician: To the be Examiner: On the basi and manner	s of examination an	e, death nd/or inv	occurred at the tirestigation, in my c	me, date and place pinion, death occu	e, and due to the rred at the time,	cause(: date an	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the I complet	Me	29b. Signature and title of certifie				29c. Licens			29d. Da	ate signed (Month	, Day, Year)
	15+1		J. 1404 CU	tetwal,	ND		D63	748		00	tober	16,2009
•			30. Name and address of person Jocelyne Koua					e, Rockvi	lle. MD			
	Sta	te	31. Date filed (Month, Day, Year)	32 Reg	istrar's Signature			o, nochvi	110, 110			
	Registr		OCT 19	2009 Denter	u B.	par	Med.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** p^{M} Charles Francis Magee 10:10 /Medical October 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Ifflinder 24 Hrs. Carroll Hospice Dove House Carrol] If Under 5. Social Security Number 6. Sex . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min **1** M 2□ F Director 219-01-8938 March 20 1921 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1√2 Yes 2 No ral", or items 23a or 28a-f s' Examinat nust be notified Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 212 Saint Matthew Ct. 21158 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1942 Baltimore, Maryland 21215-0036 r than "natural", or i 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Photography Photographer Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Magee Hilda L. Evans ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madge Magee/wife 212 Saint Matthew Ct. Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kriders Church Cem 10/20/2009 Westminster, MD ture of Funeral Service Lice Printed Filmerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OVENCY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physiclan; The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) P.0. signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ② Other (Specify) W F Now € ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation ours after death. eral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signatu 29d. Date signed (Month, Day, Year) WJL 20+1 VA 555 S. Center St., Westminster, MD 21157 30. Name person who completed cause of death (Item 23a) (Type, Print) Mohit M.D. Narang 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day / 6 Physician/ OCTOBER KATHIJA 3-15 AM JALALUDDIN MULLICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washing 11116 EASTWOOD Hagerstown DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Months | Days | Hours | Min. | A 4 gust 15 /926 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 209-68-0694 A 1 M 2 XF 83 **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director Washington Maryland Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21740 Eastwood 11116 TNDIA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates. à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ₩idowed 4 □ Divorced Specify: A SIAN Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretar WATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kadar muhi deen MEERA 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Jowkeri J. Mullick-Daughto Eastwood Drive Hagerstown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State FREDERICK 10-16-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ADEN Muslim Funeral SVE 22. Name and Address of Facility 1242 EASY ST 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final aulure Operand Death Physician, ongestive disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Š Nichetes erys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine egy burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an sate has t page 2 s prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 🗷 No 1 Yes the Hospital or Attending Physician: the Funeral Director: After this certifical pleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10,16,2009 of person who completed cause of death (Item 23a) (Type, Print)
FAI / OR AL MN - /282/ OOKLIII Ave -MD SHAHEEN /OBAL MD. 31. Date filed (Month, Day, Year) State OCT 1 9 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13,2009 Year **Physician** Ellen Mae Mears October 0 6:00 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline 326 N. Main Street **Federalsburg** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/27/1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 216-18-2191 Maryland Director Usual Residence of Decedent 3a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 □ No Director MD Caroline Federalsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21632 USA 326 N. Main Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or iter dical Examiner 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk **Grocery Store** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James K. Fitzgerald, Sr. Katherine Downes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24929 Deal Island Rd, Dames Quarter,MD 21821 Vernon Lyons/son 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If It any injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva Oct. 14, 2009 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Thurs 13 E. Grove Street, Delmar, DE 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ON VESTIVE HEART /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 1 Live birth 2 Fetal dea: ned by the atter 3 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ VERTEN SION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CHOLESTEROL 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 No 1 ☐Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Il or Attending Patter death. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier C1-0004569 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DELMAR- DE GORGU 8 E

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 15 2009

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 34946 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21,2009 Year **Physician** oct. 9:40P WILLIAM CHARLES MEIER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2785 BERRY HILLS ROAD WALDORF CHARLES 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days Hours Min. 72 Director 286-32-0605 9-23-1937 OHIO Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a life item for it at morified at WALDORF 1 □Yes 2 No MD. CHARLES Director 2 should be filed within 72 hours after death with the n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2785 BERRY HILLS ROAD 20603 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

X Yes 2 □ No ARMY
If Yes, Give
Year or DatesRET LYT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 COL • Specify. <u>Ş</u> Specify: WHITE 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RET. LT.COL.) U.S.ARMY 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM C. MEIER, SR. WILMA A. GRAESING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Pages 1 and 2 DONNA L. MEIER-SPOUSE 2785 BERRY HILLS RD. WALDORF, MD. 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ARLINGTON NAT.CEM. 12-23-09 ARLINGTON, VA. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 □Yes Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home Statemen 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred * Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 114 31. Date filed (Month. Day, Year) State Registrar

			1 - State of Mar Registrar		artment of He rtificate of De		ental Hyg	leg. N.2009	34947
	Physici	an	1. Decedent's Name (First, Middle, Last) JERRY McCLAIN				2. Date of Dea Month	Day Year	3. Time of Death
#	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	OCTOBER	4c. County of Death	
	and the second second second		NMS HEALTH CARE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	HAGERS	TOWN	9 Date of Birth	WASHI	
ĥ	Funeral Director		227-76-7902 1\(\frac{1}{2}\) M 2\(\superstack{\text{F}}\) 57			Hours Min.	8. Date of Birth (Month, Day 9/20/19	952 TEN	nplace (State or Foreign Intry) NESSEE
	land ow it		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f sh	Director	WV BERKELEY	1	MARTINSBURG	à			1 □ Yes 2 □ No
036	th with the 23a or 2 ist be no		10e. Street and Number 4379 SHEPHERDSTOWN ROAD		10f. Zip Code 2540)4		I0g. Citizen of What Co USA	untry?
	72 hours after death with the Maryland natural", or Items 23a or 23a-f show disal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	I	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	anic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
1215-0036	e filed within 72 hours after death with the Marylan Il Hygiene. other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occupation be kind of work done during DO NOT use retired) NSPORTATION	ing most of workir	I	16b. Kind of Business/I	ndustry DEPARTMENT
arylan	9 C C C	To Be Co	17. Father's Name (First, Middle, Last) HERBERT A. McCLAIN	(NA)		B. Mother's Name		Maiden Surname)	
	and 2 should raith and Men 27 is marke er traumatic		19a. Informant's Name/Relationship (Type. Print) ELIZABETH McCLAIN/SPOUSE	I	ng Address (Street and SHEPHERDSTO			r, City or Town, State, Z G,WV 25404	ip Code)
	Pages 1 and ment of Healt ant: If item 2 ant: or other any or other		20a. Method of Disposition 1 □XBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cre ROSEDALE C	osition (Name of ematory or other place) EMETERY	0CT. 2	27,	20c. Location - City or TMARTINSBURG	
Balt	permit. Par Departmen Important: any Injury		21. Signature of Funeral Service Licensee Chaules M. Brown	2:	2. Name and Address of 327 W. KING	4.5		L HOME PO BOX G, WV 25402	(821,
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	0	iter the mode of dying,	such as cardiac o		rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a company)		0.000	1000			
)	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that bitted exercise)						
5875U, c	ficate be executed physician and s the burial-transit	edical Exa	that initiated events resulting in death) Last c. Due to (or as a c						
C. BOX	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf 1 ☐ Live birth 2 [4 ☐ Pregnant at tin	23d. Date of deli Month	very Day Year				
<u>8</u>	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but r		underlying cause given i	in Part I.		bacco use contribute to	
cords,	law requi as been s 2 should	leted	Chance Ridney Dislote	-			1 Y Y 24a. Was a		bbably 4 ☐Unknown topsy findings available
a E	The ate h	Completed	Hopenins				autop:	sy prior to o med? death?	ompletion of cause of 2 □ No
vital	yslciar s certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier		6. Place of Death		ne) ence 6 □Other (Spec	sifu)
n 0r	dIng Physician: n. After this certific funeral director,		27. Manner of Death 1	28b. Time o	28c. Injury at Work?	t 2	28d. Describe h	ow injury occurred	ary)
UNISION	I or Attend after death Director: / in by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc. (- At home, farm, str Specify)		s 2□No	28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of examiner: On the basis of examiner and manner states	amination and/or in	th occurred at the time, nvestigation, in my opin	date and place, a nion, death occurre	and due to the ded at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License n	umber	2	29d. Date signed (Month	n, Day, Year)
)			30. Name and address of person who completed cause of deat	KNP	1/2/18	578		10-21-20	109
	2		Michelle Eyler ERNP 16	7014 Ma	rsh Pike H	kjerstu	nmp	21742	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	Signature		U		_	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34948 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year MILTON MATHEWS October 2009 2:07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday **Funeral** 1 AM 2 □ F 91 078-16-4505 5-7-1918 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be neithfied at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No MD Frederick Mt. Airy 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 13124 Manor Drive 21771 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 XYes 2 No
If Yes, Give WWII
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mathews 2 Germane Longhurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gisele Mathews Daughter 13124 Manor Drive Mt. Airy Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cremation 10-26-2009 | Smithsburg, Maryland 21. Signature of Euneral Service 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick, MD 21701 3a. Part 1. Ver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line.

Immortate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Ye a 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 I No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 25. Was case re erre to medical examiner? performe 1 □Yes 2 Z No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/2 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

09-08240	
Julieann Mason	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar	rtificate of	Death	ornar riyg	Reg.		09 3494			
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death	ay Year	3. Time of Death			
edical Exami	ner	Juliann Ruth Mason			(October 23,	2009	1900 hrs			
		Facility Name (if not institution, give street and number) University Hospital	ľ	4b. City, Town, or Locati Baltimore	ion of Death		4c. County of Death				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year If U	Jnder 24Hrs. 8	3. Date of Birth(MM/DD/YYYY) 9. Bir				
Director		217-15-7942 1 M 2 XF	29 Yrs		ours Min.	June 24	- 1980 Foreig	ountry) MD			
		Usual Residence of Decedent					7 2300	10d. Inside City Limits			
, any	10a. State 10b. County 10c. City, Town or Location										
land f sho	힏	MD	E	Baltimore		-1		1 X Yes 2 No			
Mary r 28a- ed at	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?				
death with the Maryland or items 23a or 28a-f show any must be notified at once.		4 North Kresson Street 11. Marital Status 12. Was Decedent Ever in U	13 Wa	21224 as Decedent of Hispanic			U.S.A.	rican Indian, Black,			
eath w items ust be	Funeral	1 X Never Married 2 Married Armed Forces?	lf Y	es, specify Cuban, Mexi	ican, Puerto Rio	can, etc.)	White, etc.				
after d al", or	by Fu	3 Widowed 4 Divorced of Dates:	1	Yes 2 X No spec	ecify:		Specify: V	White			
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she	ed b	15. Decedent's Education (Specify only highest grade completed)		it's Usual Occupation (G lost of working life. DO N			6b. Kind of Business/	Industry			
36 in 72 l	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				´	D1 D-				
-00; d with giene ther the	mo	12 17. Father's Name (First, Middle, Last)	<u> </u>	Clerical 18.Mo	other's Name (Fi	irst, Middle, Ma	Real Es	tate			
21215-0036 Juid be filed within 72 hours after Mental Hygiene. marked other than "natural", ic event, the Medical Examiner	Be	Louis M. Mason		El	lizabe	th M.	Lanahan				
D 21 should I and Mer 7 is mar natic ev	ဥ	19a. Informant's Name/Relationship (Type, Print)	19	g Address (Street and							
MD and 2 sho alth and 27 is raumati		Louis M. Mason/Father 20a. Method of Disposition 20b.		Hickory sition (Name of cemetery		Stewar	tstown, 20c. Location - City o	PA 17363			
Ore,		1 X Burial 2 Cremation 3 X Removal from State	cremator New	ver Freedom In _ the	Oct	. 28,	_				
Baltimore, permit. Pages 1 an Department of Hea important: If iter	7	4 Donation 5 Other Specify:	aptist	Cemetery Name and Address of Fa	7 20		New Free				
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma jujury or other traumatic ex		James J. Harterstein III		S. Main	St	. нагт Stewar	enstein M tstown.	ortuary, Inc PA 17363			
Physician		23a. Part I. Enter the disease, or complications that caused the death						Approximate Interval Between Onset and			
/Medical kaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple inju	ıries					Death			
tammer		or condition resulting in death) Due to (or as a consequence of	of):								
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last events resulting in death). Last	of).								
uted id ansit		d.									
Sox 68760, death certificate be executed to attending physician and offer use as the burial - transit	dica	MENDED 20b per fh g898 12-28-09 vt 23a,27,28a-f,permE, g897 11/9/09 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery									
760, icate be physical the buri		IF FEMALE: 23c. If yes, outcome of preg	gnancy				23d. Date of delive	•			
c 68 certifi ending use as	Physician	past 12 months? Live birth 4 Pregnant at time of do		etal death 3Ec ther (Specify)	ctopic pregnanc	У	Month	Day Year			
Box e death c the atten ed for us	nysi	1 Yes 2 No 9 V Unknown g Unknown		THE (Opposity)							
tal Records, P.O. Box 68' rian: The law requires that the death certificate certificate has been signed by the attending ector, page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause given i	in Part I.		acco use contribute to				
S, P uires t n sign Id be o	ed t							bbably 4 Unknown			
ord aw req as bee	plet					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of			
Rec The licate h	Completed					1 Y Yes 2		es 2 No			
of Vital Records, ig Physician: The law requir offer this certificate has been someral director, page 2 should	Be	25. Was case referred to medical examiner? 1 V yes 2 No Hospital: 1 I Inpatient 2	7 ED/O 1 - 1/2 -	TOthor	eath (Check onl		esidence 6 Other				
n of Vit ding Physic 1. After this funeral dire	- To	1 V Yes 2 No 1 Patient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatien				esidence 6 Oth	er			
	tion	1 Natural 5 Pending (Month, Day, Year)	Fd 6.1	Yes 2	2 X No S	ubject	fell from	balcony			
Division tal or Attendi rs after death. al Director: /	fica	2 X Accident Suicide 10/23/09 Fd 10/23/09 Suicide 6 Could not be 28e. Place of Injury - At r			ng, etc. 28	8f. Location (St	reet and Number or F	tural Route Number, City Paul Street			
Dipital of ours at filled filled	Certification:	4 Homicide determined (Specify) house			В	altimor	e, MD	Tadi Street			
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director:	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination and property of the basis of the basis	dge, death occu and/or investiga	rred at the time, date an ition, in my opinion, deat	nd place, and du th occurred at ti	ue to the cause he time, date a	(s) and manner as stand and place, and due to t	ated. the cause(s)			
- 5 is is 8	Me	and manner stated. 29b. Signature and title of certifier		29c. License num	nber		29d. Date signed (M	onth, Day, Year)			
		Hand Thuthall, MA		O.C.M.E.			October 24, 200	09			
		30. Name and address of berson who completed cause of death (Iter Pamela E. Southall, MD Assistant Medical Exa		1 Penn Street, Ba	altimore MC	21201	·				
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signat		enin Sueet, Da	animore, IVIL						
Regis		007 2 0 2000 6	1. 4	barrel							
DHMH 17 Rev 1/2	001		ORIGINA	NL		DGM	E				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7,2009 Physician October 9:10AM William Nelson /Medical Arthur 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Garrett 2204 Mosser RDMcHenry 8. Date of Birth
(Month, Day, Year)
Tan.] 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours 1 X M 2 □ F Yrs 1919 214-03-4520 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examinations. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Garrett McHenry 10g. Citizen of What Country? 10e. Street and Number U.S.A. Completed by Funeral 21541 2204 Mosser RD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter Arsenal Co. 11 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amelia Belinda Clayton ပ္ William Nelson Arthur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Mosser RD., McHenry, MD 21541 Marie Nelson/ Wife 20b. Place of Disposition (Name of Record of Company or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/13/09 Flintstone, MD 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 203 S. Second St., Oakland, MD, 23a. Part 1. Enter the disease, or complication, this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rena **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner •pital or Attending Physician: The law requires that the death certificate be executed ours after death.
Peral Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burta-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L the Hospital 29a. Certifier tipecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 311Nth Fourth Street Suite +1, Dakland, Md 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34951 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October Manuel Naveira Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury, Maryland Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral **1** M 2 □ F 146-16-6319 Director 86 6-29-1923 Wharton, NJUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 No DE Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 187 Delaware Ave. 19956 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White <u>会</u> 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Foreman construction/union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Naveira Sr, Balbina Condez ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerda Naveira (Wife) 187 Delaware Ave. Laurel. De. 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delaware Vet. CEm. 10-19-2009 Millsboro, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon Laurel, De. 19956 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dannigen Approximate Interval Between Onset and Death Immediate Cause (Final PERFURATED SETTIC SHOCK DUODENAL MILLEY INK EROM disease or condition resulting in death) Due to (or as a consequence of): ATHEROSCLEROTIC HEML Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine OBSTRULTIVE CHRONZ PNLMONAMY Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MALNUTRITION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ADVANCED DEMEND autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, P.O. Division of Vital Records,

The law requires that the death certificate be executed attending physician for use as the burla the detached þ signed I cate has by page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Institution or other traumatic event, Ite Institution

Physician

/Medical

Examiner

and burial-trar

the SB

Baltimore, Maryland 21215-0036

show

ed other than "natural", or items 23a or 28a-f shore event, the Medical Examiner must be notified at

MAP

IVA

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

29c. License number D 666 111

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

on ov , MO

1324 BELMONT AVE, STE 105

SALLBURY, MO 21801

MCCUZI G. DANIEL 32. Regisar's Signature 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009 34952 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician October 11, 2009 Agnes Agatha Poland 1:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Westernport Moran Manor Health Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. | 9, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 94 218-38-0372 Year) 1914 1 □ M 2 1 F West Virginia Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Experience must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV. Piedmont Mineral Funeral Director 1 XYes 2 ☐ No Zip Code 26750 10e. Street and Number 10g. Citizen of What Country? 28 Childs Ave. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 □Yes **XX**No þ Specify Specify 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Smith Anna Wallace ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Poland/son HC 86, Box 426, Fort Ashby, West Virginia 26719 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadow Point Cemetery 20a. Method of Disposition 20c. Location - City or Town, State ₩XBurial 2 Cremation 3 Removal from State Keyser, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses <u>111 Church St, Westernport, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebrovasalor accidental stroke Immediate Cause (Final acut **Physician** disease or condition resulting in death) Jacy S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Decuertipo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No autopsy perform certificate 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/ No 1 🗌 Yes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Date of Injury (Month, Day, Year) 27 Manner of Death Natural 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 221244 10/12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, MD 21532 DCT 13 2009 32. Registrar's Signature 31. Date filed (Mo State backs Registrar

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

Ken R. Buczynski,

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•	7		V	

Year

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Edith Marie Pariseau October 0 2009 11:30 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett Dennett Road Manor Nursing Home 0akland Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min 1 M 2 X F Months 216-44-0425 Director March 13 1918 California Usual Residence of Decedent 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Exercitor roughly at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Garrett 0akland filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Mary Drive 21550 Funeral United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any hijury or other traumatic event, the Made once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Edward Sima 2 Anna Dell Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Pariseau, Son 422 N. Third Street, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 10/13/2009 Cumberland, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
David A. Burdock Funeral Home, P.A. Katherine 21 N. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡1√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 0006(801

Registrar

Year 14

OCT

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street

32. Registrar's Signature

mi

State of Maryland / Department of Health and Mental Hygiene? 000

34951

			1 - State of Maryland / Dep Registrar Ce	artment of Health and ertificate of Death		ene2009 34954	
	Physici		1. Decedent's Name (First, Middle, Last) Christine Lee Mac Quilliam		2. Date of Death Month October	1 Pay 200 8 ar 8 . 00 a M	
1	/Medio Examir		4a. Facility Name (If not institution, give street and number) 44786 Three Coves Road	4b. City, Town, or Location of Dea		4c. County of Death	
- Auf	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 □ F 79 Yrs.	Hollywood If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Y	St. Mary's 9. Birthplace (State or Foreign Country) Washington, DC	
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L. MD St Mary's Hollywoo			10d. Inside City Limits 1 □ Yes 2ဩ No	
	h with the 23a or 28	Funeral Director	10e. Street and Number 44786 Three Coves Road	10f. Zip Code 20636	-	Citizen of What Country?	
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examinar roust be notified at	by Funer	1 ∐ Never Married 2 ∐ Married 1 ∐ Yes 2 ZNNo	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 □Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	within ene. than "	Completed by	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) retary	rking	b. Kind of Business/Industry	
Maryland	2 should be filed vand Mental Hygi is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Edward Johnson	18. Mother's Na. Helen	me (First, Middle, Mai Johnson	iden Surname)	
, Mar	and 2 should ealth and Mer n 27 is marke ier traumatic	·		ng Address (Street and Number or R 6 Three Coves Roa			
Baltimore,	permit. Pages 1 au Department of Hee Important: If item any injury or othe once.		4□Donation 5□Other (Specify) Brinsfie		0/2009 C1	c. Location - City or Town, State narlotte Hall, MD	
Ball	permit Depar Impor any in		Kyle S. Simons M01206	2955 Hollywood Ro	ad,Leonard		
	Physician // Medical Examiner as the burial-transit as the burial-transit	ledical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		o or respiratory arrest	Approximate Interval Between Onset and Death 4 urs 10 month	
		Physician/Medic			☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, F	res ti signe be d	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 to hknown	
Vital Records,	ician: The law re certificate has be ector, page 2 sho	Completed	25. Was case referred to medical		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
	Physician: r this certifica ral director, p	To Be	examiner? 1 Yes 2 1 No Hospital: 1 Inpatient 2 ER/Outpatien	Othern	ath (Check only one)	e 6 ☐ Other (Specify)	
Division of	vttending Phys death. ctor: After this in the funeral dir	ation: 1	27. Manner of Death 1 Avatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time o		28d. Describe how i		
Divis	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, S		
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in the Funeral Director of the Funeral Director	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deating the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occi	urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)	
	So So Site	2	29b. Signature and title of certifier	29c. License number D 60 56 4 8 Print) D m D 204	φ 10	Date signed (Month, Day, Year)	
	m		30. Name and address of person who completed cause of death (Item 23a) (Type, 24035 Three Notch Road Hollywoo	Print) 206	36 Gi	urdeep S. Chhabra, M.I	
	Stat Registra	~	31. Date filed (Month, Day, Year) 32 Hegistrar's Signatur	wed			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 34955 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Catherine L. (Eaton) Robb October 2009 0446 18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospita Eastor Talbot Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Apr. 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 219-07-7342 92 Yrs Î917 Maryland **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Kent Harrington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5107 Milford-Harrington Highway 19952 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked oth Be William Eaton Ola (Vickery) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is any injury or other trau Sandra Parrott/Niece 7286 Glen Ridge Rd., Easton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2009 Harrington, DE Hollywood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Melvin FH, 15522 S. DuPont Hwy., Harrington, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriaf-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s this certificate had autopsy 1 ☐ Yes 2 ☐ No 2 No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation M 1 ☐ Yes 2 □ No Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a

To the Funeral C

completely filled 29a. Certifie tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

920 Market Street, Denton, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wafik Zaki, MD,

OCT 22 2009

31. Date filed (Month, Day, Year)

0047534

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Tromayne Robinson 2009 34956 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 10, 2009 0948 hrs Tromayne Lionel Robinson, Jr. **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore University Hospital STU 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** Months Days Hours May 16, 1995 Director 212-45-0170 Country) Maryland 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any 10a. State 1 X Yes 2 No Caroline Federalsburg MD permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: 1f item 27 is marked other than "natural", or items 23a or 28a-f sho hijury or other reaumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 3462 Laurel Grove Road #1F 21632 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 X No Yes Black Yes 2 X No specify: Specify: Divorced f Yes. Give Year Widowed ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 N/A N/Aq 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rolanda Peterson Tromayne L. Robinson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3462 Laurel Grove Rd. #1F, Federalsburg, MD 21632 Rolanda Peterson/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/17/09 Preston, Maryland Johns Cemeterv Donation 5 Other Specify 22. Name and Address of Facility Framptom Funeral Home, Signature of Funeral Service Licenses CFSP Kelvule Main St., Federalsburg, MD 21632 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Head and Neck Injuries Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical e attending physician a for use as the burial AMENDED UNPENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. à 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been si, page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 Yes 2 1 🗸 Yes No certificate the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifinabletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month Day, Year) Oct 9, 2009 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Occupant auto fixed object collision 1 Natural 1447 hrs Yes 2 🗸 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 4160 Laurel Grove Road, Federalsburg, MD (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 11, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD 31. Date filed (Month. egistrar's Signatu State

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Registra

State of Maryland / Department of Health and Mental Hygiene 2009 31.057

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Madical Evaninar must be notified at any injury or other traumatic event, if a Madical Evaninar must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4 5 4 4 4 4 4 4 4 4 4 4		Certiii	cate of L	veatn	Reg.	2009	3495			
1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death			
Harold Kenn	eth Reynol	ds			October 0	17, 2009	6:57 a ^M			
4a. Facility Name (If not institution, give s	street and number)		-	Location of Death		4c. County of Deat				
18599 Pleasant M	lanor Road			y's City		St. Ma	ry's			
5. Social Security Number 448-01-9389 6. Sex 1 🖾 M 2 🗆 F 88 7. Age (In yrs. last birthday) 1 🛣 M 2 🗆 F 88 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 Months Days Hours Min. 03/24/1921										
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
Maryland St. Mary's City 10e. Street and Number 18599 Pleasant Manor Road 20686 US 11. Marital Status 1										
10e. Street and Number	, St		Off. Zip Code		100	Citizen of What Co	1 ☐ Yes 2 🛣 No			
			2068	6	109.		aria y .			
18599 Pleasant M	U S A	vices Indian								
11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W 1 □ Yes 2 □ No If Yes, Specify: Specify:										
	Kind of Business	White								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin (Give kind of work done during most of working life. DO NOT use retired)										
5+ Commissioned Officer U.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname										
17. Father's Name (First, Middle, Last)	D 1 1					uen sumame)				
Walter Lowell	Reynolds			Violet	Lites					
19a. Informant's Name/Relationship (Type	pe. Print)	1				ity or Town, State, 2				
Elizabeth A. Reyno						Maryland				
20a. Method of Disposition 1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols 20c. Location - City or Town, State 10/21/2009 Charlotte Hall, MD										
21. Si voi le of uneral Se vice Licens	2 1100	22. Nai	me and Addres	s of Facility Bri	nsfield F	uneral Ho	ome, P.A.			
Edward N. Brinst 23a. Part 1. Enter the disease, or compli	ield, Jr. MOO			•		rdtown, N	Approximate			
shock, or heart failure. List only or	ne cause on each line.	i. Do not enter the	e mode or dying	g, such as cardiac o	or respiratory arrest	1	Interval Between Onset and Death			
Immediate Cause (Final disease or condition	Myocardial	Infarct	ion				2 days			
resulting in death)	Due to (or as a consequ	ence of):					<i>C</i> (1)			
Sequentially list conditions	Conjestive	Heart F	allure				6 months			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dunito (or as a consequ	iones offi								
that initiated events		10 years								
resulting in death) Last	Due to (or as a consequ	ience of):					14 days			
d. Aspiration Pneumonia										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 23d. Date of the past 12 months? 4 □ Pregnant at time of death 5 □ Other (specify) Month										
Part II. Other significant conditions cor	ntributing to death but not resu	ilting in the underly	ying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
Parkinson's Dise	-		-		1 □ Yes	2 □ No 3 □ P	robably 4 LUnknow			
					24a. Was an autopsy	prior to	utopsy findings availab completion of cause o			
					performe 1 □ Yes 2	d? death? LNo 1 ☐ Yes	2 🗆 No			
25. Was case referred to medical examiner?				26. Place of Death	(Check only one)					
1 Yes 2 KNo	lospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Othe	r: 4 🗆 Nursing Ho	me 5 Residenc	e 6 □Other (Spe	ecify)			
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	injury occurred								
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	et and Number or R State)	ural Route Number,							
29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
29a. Certifier (Check only one)	and manner stated.	29b. Signature and title of certifier 29d. Date signed (Mo.								
(Check only 2 ☐ Medical Examil one)	and manner stated.		29c. License	number	290	. Date signed (Mon	th, Day, Year)			
(Check only 2 ☐ Medical Examil one)	The care				290					
(Check only 2 ☐ Medical Examinone) 29b. Signature and title of certifier Pull B.	Thavein	.00-) /T	D003	number 32651	290	10/19/200				
(Check only 2 ☐ Medical Examil one)	Thavein ompleted cause of death (Item		D003	32651		10/19/200				



State of Maryland / Department of Health and Mental Hygiene 34958 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Bonnie Lou Rodriguez 2009 October 3:44 p /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 122 Huntsman Dr. Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year I f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 14, 1957 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗗 F 215-68-2436 Months Days Hours 52 KY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits MD Funeral Director Elkton Cecil 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? õ must be 122 Huntsman Dr. 21921 d other than "natural", or items 23a event, the Medical Examiner must I USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Custodian Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or ---Gustava Gray Mabel Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kara Mireles/Daughter 122 Huntsman Dr., Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. West Chester, PA October 15, 2009 e of Funeran Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cee /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer Tal The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) o the 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? res page certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 2□/€ P 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. After Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 ☐ Accident 5 Pending Injury n 24 hours after death.

Ie Funeral Director: Af

Illetely filled in by the fun investigation 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 hoi **To the Fune** completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD m coe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State OCT 1 9 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

		•	For State Registrar		. ,	Ce	rtificate of	Death)	Re	g. No.	009	34939
			1. Decedent's Name (First, Middle, La	ast)	-					ate of Death	1	Vear	3. Time of Death
	Physicia /Medic		Marilyn		Ros	shwa]	l.b		Oct	ober_	18, 2	2009	4:00 A M
· Carrie	Examin		4a. Facility Name (If not institution, gir				4b. City, Town, o					unty of Death	
200			5600 Wisconsin Av		(In yrs. last	hirthday)	Chevy Chase Structure Chase Cha					ntgomer	y lace (State or Foreign
	Funeral Director		082-18-4961	1 □ M 2 K) F	85	Yrs.	Months Days	Hours	Min. Oct	ate of Birth Month, Day, . 15,	1924	4 New	York
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation					10	Od. Inside City Limits
	Maryl -f sho	호	Maryland Montgor	nerv	Chev	v Cha	ase						1 □Yes 2 🔀 No
	r 28a	Director	10e. Street and Number			, 0	10f. Zip Code			10	g. Citizer	of What Coun	try?
	h with		5600 Wisconsin Av	ve., #409			20815				U.S	.A.	
	ems deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Decedent of H	lispanic O	rigin? (Specify) an, Puerto Ricar	es or No-	14.	Race - Americ Black, White, e	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exactional County for Indianal and aumatic event, the Medical Exactional County for	þ	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1	0		1 □Yes 2X No				Sp	pecify: Whi	
5-0	72 hc	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usual Occup kind of work done	durina mo	st of working	1	16b. Kind	of Business/Inc	dustry
121	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-			DO NOT use retire	•			Dece	orating	
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Las	<u>Z</u>		TIICEI	LIUI DESI		ner's Name (Firs	st, Middle, N			
an	Mental Mental arked o atic eve	To Be	Peter Besunder	,				Sad	lie Fogl	.er			
ary	shoul tnd M s mari umati	F	19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Numi	ber or Rural Ro	ıte Number,	City or To	own, State, Zip	Code)
ž	alth a alth a 27 is		Alan Roshwalb (So	on)		11510	Colt Te	rrace	e, Silve	r Spr	ing,	MD 209	02
ore,	es 1 a of He of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	X Dames of trans State	20b. Plac	e of Dispo	osition (Name of matory or other pla	ce)	Date	2	20c. Locat	tion - City or To	wn, State
<u>E</u>	Page ment ant: If ury o		4 ☐ Donation 5 ☐ Other (Special	ify)	Beth	Dav:	id Cemete	ry	10/19/0)9	E1mo	nt, NY	
Balt	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic e once.		21. Signalur 1 Funeral Service Lu	MI MI	01008	2	2. Name and Addr Torchinsk 254 Carro	ss of Faci y Hel	orew Fur	neral Vashin	Home	, DC 20	012
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death.								Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Congest	ive H		Failure						Onset and Death 2 Years
and the	/Medical Examiner		Toodking in dodding	Due to (or as a									
		ē	Sequentially list conditions, if any, leading to immediate	b. Atheros					·				
B	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									1	
oʻ	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequer	nce of):							
68760,	ate be nysicia ne bu	Medical		d									
89 3	E Se Se		IF FEMALE:			-						1	_
O. Box	law requires that the death oe as been signed by the attendi 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of the common of the c	2 🗌 Fetal de	eath 3	☐ Ectopic pregnan ☐ Other (specify)	су			230	d. Date of delive Month	ery Day Year
σ.	that the dense by the detached		Part II. Other significant conditions	contributing to death bu	t not resulti	ng in the u	underlying cause gi	ven in Part	tl.	23e. Did tob	acco use	contribute to the	he cause of death?
Vital Records,	uires t signe id be	d by								1 ☐ Ye	s 2 🗆	No 3□ Prol	ably 4 🖔 Unknown
CO	w requir been s should	Completed								24a. Was ar	n :	24b. Were auto	ppsy findings available mpletion of cause of
Re		dmc								autops	ned?	prior to co death? 1 ☐ Yes	
ta	sician: The certificate b irector, page		25. Was case referred to medical		-		<u> </u>	26. Pla	ce of Death (Ch		2 X No	I LI Yes	2 LIN0
<u> </u>	Physician: this certificatal director, p	To Be	examiner? 1 ☐ Yes 2 🎦 No	Hospital: 1 ☐ Inpatie	nt 2 EF	R/Outpatie	ent 3 DOA Ot	har:	Nursing Home			☐Other (Specia	(y)
n of	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui		Bb. Time o	of 28c. Inju	ry at rk?	28d.	Describe ho	ow injury o	occurred	
Sio		atic	2 Accident investigation	on				Yes 2					
Division	al or Attend s after death I Director: id in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At hom . <i>(Specify)</i>	e, farm, st	treet, factory, office			_ocation (St Cify or Towr		Number or Rura	al Route Number,
	To the Hospital or A within 24 hours after D to the Funeral Director Completely filled in by	Medical (29a. Certifier 1 🛣 Certifying F (Check only one) 2 🗆 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	examinatio	edge, dea n and/or i	th occurred at the nvestigation, in my	time, date opinion, d	and place, and leath occurred a	due to the c t the time, d	ause(s) a ate and p	nd manner as lace, and due t	stated. o the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	0 -	٨		29c. Licen	se numbe	г	2	9d. Date	signed (Month,	Day, Year)
	18		1 (1/olith	1 Sle n	1		D 2	23556			0cto	ber 18	, 2009
			30. Name and address of person who Robert H. Blee,				Ave., Cl	nevy	Chase,	MD 20	0815		
	Sta	ate	31. Date filed (Month, Day, Year)	00.5	4. 0'								·
	Regist	rar	OCT 19 20	09 Peners	, ß.	190	Red						

DHMH 17 Rev 1/2001

Funeral 217-12-2904 1 □ M 2 🗸 F 88 Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show FREDERICK FREDERICK MD. Funeral Director 10e. Street and Number 10f. Zip Code MADISON ST. 21701 permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Event is an once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 12 11+ 17. Father's Name (First, Middle, Last) Be Robinson 6torgt W. 0 19a. Informant's Name/Relationship (Type. Print) SISTER) DR. CHLORICE DAVIS 1639 N. WOOD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State OCT. 17,2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses d. ollis 110 WEST SOUTH ST 23a. Part1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he we failure. List only one cause on each line. Immediate Cause (Final **Physician** Coronary intern disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending PhysIcian; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 24a. Was an 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 5 Pending investigation within 24 hours after action.

To the Funeral Director: Af 1 ☐Yes 2 ☐No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier MD 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUR Frederich lanen 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 34960 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ELOISE OLIVIA ROBINSON 8 2009 4:59 A^{M} October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Scot, 27, 1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry PRIVATE FAMILLES 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CINN. OHO 20c. Location - City or Town, State 22. Name and Address of Facility GARY L. ROLLINS FUN. PREDERICK MO 21701 Approximate Interval Between Onset and Death Months 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 **X**No 1 ☐Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Anthony Michael Sparacino

2009 34961

			- For State AMENDE	ED #9 PER	FH Cert	ific y te9f	Death	CCH	DKN	Reg.		00	7 34	70
Phys		n/	Decedent's Name (First, Middl	e,Last)					2. Da	te of Death	Dav Yea	_	. Time of Death	
edical Exa								Oc	October 13, 2009					
			Anthony Michael Sparacino 4a. Facility Name (if not institution, give street and number) 16029 Dorsett Road				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George's			
Fune	rai		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye	ear If Under	r 24Hrs. 8. E	ate of Birth	(MM/DD/YYYY	g. Birthr	place (State or	
Direct			213-94-9525	1 <u>X</u> M 2_F	44	Yrs.	Months Da	ays Hours	Min. Dec	c. 16,	1964	Foreign Coun	Marylai Vingini	nd a
5	,	-	Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City	Town or Location	on					1	0d. Inside City Li	imits
T MY 31	انه		Maryland Prince	Georges	1 '	aurel							1 X Yes 2	No
uylanc	of onc	횽	10e. Street and Number	Georges		AUL CI	10f. Zip Code			10g	. Citizen of W	hat Countr	y?	
he Ma	iffed a	Dire	16029 Dorsett I	Road			20707	7		Ur	nited S	tates	s of Ame	ric
with t	De not	ja	11. Marital Status	12. Was De	cedent Ever in U.S		s Decedent of I	lispanic Orig		Yes or No-	14. Race		n Indian, Black,	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and mental Hyging the Maryland feath and mental Hyging them "matural", or items 33a or 28a-f she	must	Funeral Director		arried Armed F	2 No		es, specify Cub		, uerto ritodii	, 0.0.)			,	
s after	niner.	2		vorced If Yes, Give Ye or Dates:			Yes 2 X N		kind of work d	one I	Specify: 16b. Kind of Bu		asian _{dustry}	
2 hour.	Exan	P F	15. Decedent's Education (Spe Elementary/Secondary (0-12)		,		ost of working li				, 55, 14114 OF DE		,	
336 thin 7; re.	edica	Completed	12	1	,	Field	Engine				Commu		cions	
21215-0036 sold be filed within 7 Mental Hygiene.	the M		17. Father's Name (First, Middle	, Last)				1			aiden Surname	e)		
121 1 be fi. ental F	vent,	a	Angelo		Sparac	ino		Mari	lyn J	oan (Gileno	un Ciri-	Zin Codo)	
Should Must Miss and	ratic e	٩	19a. Informant's Name/Relations		othor		Address (St						ad 2162	9
e, MD 21215-0036 I and 2 should be filed within 72 hours after de then and Montal Hygiene.	fant: 11 tem 2.1 is market other than "natura", or tems 2.2a or 2001 show any or other traumatic event, the Medical Examiner must be notified at once.		Marilyn Weil 20a Method of Disposition			Place of Dispos	ition (Name of	cemetery,	Date	e	20c. Location	- City or T	own, State	
Baltimore, permit. Pages I as Department of He	other		1 XBurial 2 Cremation		on otate		ner place) Pa n Memo:		10/1	9/09	East	on,	Maryla	nd
Baltim permit. Pa Departmen	ry or	1	4 Donation 5 Other S 21. Signature of Funeral Service		LMO		lame and Addre					the second second		
Den Den C	Ē:Ē	. 1	Raudahl P	Moor	_	12	South S	Second	Stree	t, Der	nton, M	aryla	and 2162	
Physic	_		23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and											
/Medi xamii	_		Immediate Cause (Final disease a Blunt Force Head Injuries											
			or condition resulting in death)	Due to (or as	a consequence of):								
		ner	Sequentially list conditions, if any, leading to Immediate a cause. Enter Underlying Cause											
		Examiner	(Disease or injury that initiated events resulting in death) Last	Ç	a consequence of	j):								
cuted	and transit			d										
3760, ficate be executed	e attending physician and for use as the burial - tra	edical	UNPENDED	AMENDED										
8760,	g phy:	[]	IF FEMALE: 23b. Was decedent pregnant in t	the a	outcome of pregi	nancy	etal death	3 Ectopi	c pregnancy		23d. Date of Month		ay Yea	ar
Box 68 e death certil	tendin use a	icial	past 12 months?	4 Preg	nant at time of de	- Alla	her (Specify)		9					
Bo le deat	g ä	Physicia		nknown g Unki				no pluma 1 - P	ort I	23e Did to	bacco uso con	tribute to t	he cause of deat	th?
P.O.	signed by be detach	by P	Part II. Other significant condi	itions contributing	to death but not re	esulting in the i	underlying caus	se given in Pa	art I.				ably 4 Unkn	
duires	been sign		-						- 1	24a. Was a	n 24b	. Were aut	opsy findings ava	ailable
COFC law re	has t	Completed							—	autops perform	med?	death?	ompletion of caus	
Re (certificate ector, page	5	25.11				00.5	ago of Death	(Check and	1 Yes 2	2 No	1 ✓ Ye	s 2 N	No
ician:		B	25. Was case referred to medic examiner?	al Hospital: 1	Inpatient 2	ER/Outpatient		Other ₄	(Check only	_	Residence 6	✓ Other	Scene	
of Vital Records,	Atter this uneral dir	<u>유</u>	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Time of	the same of	Injury at Worl	k? 28d	. Describe h	now injury occu			
OD (ending ath.		tion		IGHTIS CT 40	th, Day,Year) D: 2009	FOUND: 1101 hrs	1	Yes 2	No Sub	oject beat	ten			
Division tal or Attendir	Directa in by t	Certification:	3 Suicide 6 Cou	uld not be 28e. Pla	ce of Injury - At h		et, factory, offic	ce building, e					ral Route Number	er, City
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certify hours after death.	filled	Cert	4 V Homicide dete	ermined (Specify	Townhous						tate) : Road, Laure			
Divisior To the Hospital or Attendivitin 24 hours after death	To the Funeral Director: completely filled in by the	Medical	2ga. Certifier (Check only one) 2 Medical Ex.	Physician: To the beaminer: On the basis	of examination a	ge, death occu nd/or investiga	rred at the time ition, in my opir	e, date and pl nion, death o	ace, and due ccurred at the	to the cause time, date a	e(s) and mann and place, and	er as state i due to th	ed. e cause(s)	
Towith	COL	Med	29b. Signature and title of certif	and manner	stated.	-		ense number					nth, Day, Year)	
			(a 4 de	Hall	111-		0.	C.M.E.			October 1	14, 2009	9	
			30. Name and address of perso											
			Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
	St	ate	31. Date filed (Month, Day, Year		Registrar's Signati	Jre .	. 41							

			Please Type or Print in Black In-									
			1- State of Maryland / Department	artment of Health and Me rtificate of Death	ental Hygiene Reg. No. 2009 34962							
Ē	Physici		1. Decedent's Name <i>(First, Middle, La</i> st) Joanne Sampson		2. Date of Death Month	te of Death onth Day Year 3. Time of Death						
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	043-					
	Funeral Director		Memorial Hospital Easten Tabe 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birth (Month, Day, Year) 9. Birth (Month, Day, Year) Jan. 13, 1950 Ma									
Baltimore, Maryland 21215-0036	e Maryland a-f show tified at	ctor	Usual Residence of Decedent 10a. State	Federalsbu	rg		10d. Inside City Limits 1 函Yes 2 □ No					
	h with th	al Dire	10e. Street and Number 317 Old Denton Road	10f. Zip Code 21632		citizen of What Cour ited Sta						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Speci if Yes, specify Cuban, Mexican, Puerto Ri □ Yes 2		14. Race - Americ Black, White,	can Indian,					
	within 72 ho iene. than "natur the Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) embly Line Worke	'	Kind of Business/Inickle Co						
	ould be filed Mental Hygi arked other artic event, t	To Be Co	17. Father's Name (First, Middle, Last) Ben Byrd	18. Mother's Name (i								
	ind 2 sho alth and 27 is ma ir trauma			ng Address <i>(Street and Number or Rural I</i> Old Denton Road, Fe								
	Pages 1 ament of He ant; If Item ury or othe		4∑Donation 5 □ Other (Specify) Federal H	sition (Name of natory or other place) ill Cemetery 12/09	9 Fe		g, Maryland					
■ Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632									
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, last source of the cause. Enter Underlying									
Records, P.O. Box 687	ficate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of):									
	The law requires that the death certificate be the has been signed by the attending physicionage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown		23d. Date of delive	ery Day Year						
	w requires that been signed t should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the ur Right Sided 5 Hoke	No.	23e. Did tobacco use contribute to the cause of death? 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown							
	yslclan: The law r lis certificate has be director, page 2 sh	To Be Completed	25. Was case referred to medical	Of Place of Positiv	24a, Was an autopsy performed? 1 Yes 2 2 1	prior to co death?	opsy findings available mpletion of cause of 2□ No					
	Physicia r this cert ral direct		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		5 ☐ Residence	6 ☐Other (Specia	(y)					
Division or	Attending or death. rector: Afte by the fune	Certification:	27. Manner of Death 1 Manual 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 4 Homicide 6 Could not be determined 6 Death (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M Work? 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred									
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical Cer	29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	To the within To the Comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL W. Monte, W. 2195, Weshington St. EASTM, M.D. 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature 34. Apart St. EASTM, M.D. 21601									
_			30. Name and address of person who completed cause of death (Item 23a) (Type, PAUL W. Monte, ND 2195	Cushneton St.	EASTU	1, 110	21601					
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 3 2009 32. Registrar's Signature	hand		•						
DHI	MH 17 Rev 1/20	01										

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8:30 AM Rose Μ. Surritte October 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 229-44-2934 98 June 1, 1911 Louisiana **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Piney Point 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20674 USA 17268 Larimore Street Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Industry Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked ott any injury or other traumatic even Be Caroline Bordeline Louis Monvel ۴ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20671 Chingville Road Leonardtown, MD 20650 Deborah Aud-Bakley / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State October 22, 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 2009 21. Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed -tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months?
1 Yes 2 No Month Year 5 ☐ Other (specify) P.0. 9 \ Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page After this certificate 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 428 10.16.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, II, M.D. 25365 Pt. Lookout Road Leonardtown, MD 20650 ^{Year)} 2009 Registrar's Signature 31. Date filed (Monti State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:00 p M Gloria Theresa Severn 2009 October 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 21167 Winding Way Lexington Park 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🗓 F 220-68-0156 45 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Lexington Park St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20653 21167 Winding Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ∑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: 1 ∐Yes 2.21No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Depot Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Elizabeth Wiatrowski Raymond Slyvester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret H. Alvey/Life Partner 21167 Winding Way, Lexington Park, MD 20653 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brinsfield-Echols Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State, 10/20/2009 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Nonsmal Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tot as a consequence of. Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nerformed^a

Physician /Medical Examiner

be exec

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Director

Funeral

2

Completed

Be

ပ

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Experiment must be notified at

altimore, Maryland 21215-0036

Examiner burial-tran attending physician Physician/Medical the as for use signed by the a Completed certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, Be Certification: To the filled in by

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown 25. Was case referred to medical examiner?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 □Yes 2 No

26. Place of Death (Check only one)

2 🗆 No

2 No 1 Tyes 27. Manner of Death 1 Alatural

2 Accident

4 Homicide

3 ☐ Suicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Gurdeep S. Chhabra, M.D.

State Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours a To the Funeral D

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:00 PM Hugh Dalton October 18, 2009 Sterling /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20695 Charles 3839 Kahler Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F June 6, 1924 218-16-2077 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "Motical Exemitive is ust be in titled at 1 ☐ Yes 2 No Director Maryland Charles White Plains 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3839 Kahler Road 20695 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No White Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Supervisor 12 s 1 and 2 should be filed wi of Health and Mental Hygier item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth E. Camalier Lynwood Joseph Sterling other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) White Plains, MD 20695 Wife 3839 Kahler Road Marjorie Kathleen Sterling / item Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot October 21, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph's Cemetery 2009 Pomfret, Maryland 21. Signature of Funeral Service name and Address of Facility
Mattingley-Gardiner Funeral Home, P
P.O. Box 270 Leonardtown, MD 20650 ickiae fard 23a. Part /. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dving, such as cardiag respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed burial-transi and Due to (or as a conseq Box 68760, physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 20 Month Year Day 5 ☐ Other (specify) □Yes 2 No P.0. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Records, ð 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an has autopsy performed? res 2**X**INo certificate **Division of Vital** 1 □ Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) OCT 20

Abbas A. Omais, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature 32.

Waldorf, MD 20602

7C Post Office Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year rance s SKinner :36 rene 10 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death 4c Examiner Inton 9. Birthplace State or Foreign If Under If Unde 8. Date of Birth . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year **Funeral** Was hington (Month, Day, 1 M 2 X F Months Days Hours 213 42 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral KeAT 2543 20748 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 Yes, Give 2 X No 21215-0036 1 ☐ Yes 2 📈 No Specify: 3 Divorced Blade Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 1412115 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of opmetery, crematory or other place) 20a. Method of Disposition ■ Burial 2 ☐ Cremation 3 ☐ Removal from State MI Aldut 09 injury (HAGE 10 4 Donation 5 Other (Specify) 21. Signature of Funeral S ce Lice Name and Address of Facility any 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? (Month, Day, Year) injury 1 Natural 5 Pending Investigation Accident Sulcide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	Cer	tificate of D	Death	Reg.	No. 2009	34967		
Dhusi	inina	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				
Physi /Med							16, 2009	9:22 p M		
Exam	niner	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or	Location of Death Spring		4c. County of Death			
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. las.	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Montgome 9. Birthp	lace (State or Foreign		
Directo		167-30-2445 1□M 2XF 72	Yrs.	Months Days	Hours Min.	June 3,		sylvania		
pu »		Usual Residence of Decedent 10a, State 10b, County 10c, City, 7	Town or Loc	cation			11	0d. Inside City Limits		
Aaryla f shor	ċ	,		r Spring				1 □ Yes 2 📆 🖠 o		
r 28a-	Director	10e. Street and Number	silve.	10f. Zip Code		10g	. Citizen of What Coun	try?		
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r deal	Finoral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, e			
III. A I Z I 3-0030 be filed within 72 hours after death with the Maryland tall by glene. ad other than "natural", or items 23a or 28a-f show event, it a Medical Evanting must be notified at	2		1	∐Yes 2⊡ x No	Specify:		Specify: Whi	te		
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led wi Hygier her th			Re	<u>ceptionis</u>		ne (First, Middle, Ma	<u>Hospital</u> iden Surname)			
	8	i				ine L. Ho				
2 should be and Mental Is marked (raumatic ev	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ig Address (Street a			City or Town, State, Zip	Code)		
y, IVI		Clarence L. Shaw/Husband	1011	7 Tenbroo	k Drive ,		ring, MD 2			
Daltillore, Ivial ylal plat permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e		1 N Burial 2 Cremation 3 Removal from State	netery, cren	sition (Name of natory or other place	· · · · · · · · · · · ·	Date 20	c. Location - City or To	wn, State		
rmit. Pages spartment of portant: If it y injury or or		4 Donation /5 Other (Specify)		Memorial . Name and Addres		2009 R	ockville, Ma	aryland		
Depart Depart Impo	Suce	21. Signature of uneral review Licenyee	1 1	Francis J	. Collin	s Funeral	Home Inc.	g, MD 20901		
		23a. Part 1. Enter the disease, or complications that caused the death.				<u>.</u>		Approximate Interval Between		
Physicia	ın	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Exacerbation of Chronic Obstructive Pulmonary Disease								
/Medica	_	resulting in death) a. Due to (or as a consequent		IL CATALO	SELHOLIY	e rumone.	Ly Distance			
LXaIIIIIe	ш.	Sequentially list conditions,								
uted d ansit	1	Gause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
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certific certific iding p			cy				23d. Date of deliv	erv		
death ce attend	0	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	leath 3□	☐ Ectopic pregnancy ☐ Other (specify)	у		Month	Day Year		
COLCAS, P.O. BOX we requires that the death ce been signed by the attendi should be detached for use	, d	9 Unknown					1.21 1.11	b- several of death?		
S, es the iigned be de	1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1X Yes 2 □ No 3 □ Probably 4 □ Unknown			
VITAI HECOICS ician: The law requires certificate has been sign ector, page 2 should be	100					24a. Was an		opsy findings available		
1) B B C	100					autopsy performe	prior to co death?	impletion of cause of		
VITAI MEC sician: The law certificate has be irector, page 2 si	3	b 25. Was case referred to medical			26. Place of Dea	1 □Yes 21 ath (Check only one)		2 LI No		
OI VITA Physician: r this certific ral director, I	3	examiner? 1 ☐ Yes 2 🖾 No Hospital: 1 🛣 Inpatient 2 ☐ El	R/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nursing H	lome 5 ☐ Residen	ice 6 Other (Speci	fy)		
on or vital Ke ding Physician: The land. After this certificate he funeral director, page:		27. Manner of Death 5	28b. Time o Injury	Work		28d. Describe how	/ injury occurred			
VISION Attending or death. ector: Affe	3	27. Manner of Death 1 💆 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Suck Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								
Jor A after a Direc	9,4	4 Homicide determined building, etc. (Specify)	10, 147111, 011	oot, lastery, office		City or Town,				
To the Hospital or Attending P. within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	1	handed an agree of the control of th								
thin 2, the Formplet	1000	29a. Certifier (Check only one) 18. Certifying Physician: To the best of my know and manner stated. 19. Signature and title of certifier on the basis of examination and manner stated.		29c. Licens	e number	29	d. Date signed (Month,	, Day, Year)		
100		Asland July DD		Hon	6458		10/17/09			
,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, MD 1500 Forest Glen Road, Silver Spring, MD 20910								
	State	31. Date filed (Month, Day, Year) 33 Registrar's Signatu	ire							
Regi	istra	OCT 19 2009 Ceraus S.	100	Med						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 15, 10:15 MAM October 0 2009 Diana SELDES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 5, 9. Birthplace (State or Foreign Country)
RUSSIA 5. Social Security Number **Funeral** 1 □ M 2 🗙 F 94 Director 057-03-1575 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther must be notified at once. 10a. State 10b. County Rockville 1X Yes 2 No Montgomery **Funeral Director** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 1801 E. Jefferson St., #619 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Avrech Israel Leon Seldes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10509 Hutting Place, Silver Spring, MD Laura Steele, Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 N Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth David Cemetery Elmont, NY 10/18/09 21. Signature of Function Service Licensee # M01008 Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCT **Physician** /Medical Due to (or as a consequence of): Examiner ONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify) Ö ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by page 2 should be 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: # 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 2 018084 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 009 34969 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2120 PM David A. Simons, Jr. October 16. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harkord Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Director Pennsylvania 212-48-5299 July 1, 1947 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Directo Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 117 Edmund Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No Specify. <u>م</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Oliver David Alexander Simons. Sr. ൧ Jermit. Pages 1 and 2 shrobertment of Health Important: If iter any injury or once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Simons (Wife) 117 Edmund Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. 10/21/2009 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OSTEOMYELITIS Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ C. DIFFICILE COLIHS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DIABETES MELLITUS, TYPE ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PERIFHERAL ARTERIAL DISENSE performed' 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 Ho Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ∐ Yes 2 🖼 Ho Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Atatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) 29d. Date signed (Month, Day, Year) en Nountions ? DOP096 OCTOBER 19,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 FULFORD ATE, BEHIR, MODION ANDREN NOWAKOWSKI 31. Date filed (Month, Day, Year 21

Registrar

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien 2000

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			For State Registrar		State	or Marylar				ealth and N Death		Reg. No		34970
ja.			Negistrar Decedent's Nam	e (First, Midd	le, Last)			imour	-		2. Date of De	ath		3. Time of Death
J	Physici		Linda Car	rol She	erwood						Month Octobe	r 3.	2009	8:23 A ^M
r	/Medio Examir				n, give street and n	umber)		4b. City	, Town, or	Location of Death			County of Death	
			Garrett (County	Memorial	Hospita	al		kland				arrett	
	Funeral		5. Social Security N	lumber	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	**	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthi Cou 1951 Vir	place (State or Foreign
	Director		223-80-3		I I I W Z Z Z	5	58 Yrs.				June	18,	1951 Vir	ginia
	and and	1	Usuel Residence o 10a. State	10b. County	,	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Mary	Į,	MD	Garret	:t	Acc	cident							1 Yes 2□No
	7.28a	rec	10e. Street and Nu	1				10f. Zi	p Code			10g. Cit	izen of What Cou	ntry?
	38 o	0	208 Drane	e Dr.				2	1520			US	A	
	deatl	Funeral Director	11. Marital Status		12. Was Dec	cedent Ever in U	J.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No		14. Race - Ameri Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show empty injury or other traumatic event, the Medical Examinational to notified at ance.	by Fu	1 ☐ Never Marr 3 ☐ Widowed	_	ned 1 ☐ Yes	2 X No				Specify:	r violari, oto.)		Specify: Whi	
21215-0036	2 hou	Completed by		15. Deceder	nt's Education		16a. Dece	dent's Usu	al Occupa	ition		16b. K	ind of Business/In	
212	7 nin 72	plet	(Spec		st grade completed	(1-4or 5+)	(Give	kind of wi DO NOT i	ork done d use retired	luring most of worl)	king			
212	d with	E O	Lienientary/Jea	oridary (0-12)	2	(1-401 0+)	Admin	istra	ative	Assista	nt	С	ollege	
	al Hy I oth	Be	17. Father's Name	(First, Middle,	Last)					18. Mother's Nam	ne (First, Middle	, Maiden	Sumame)	
Maryland	hould be d Ment	户	James Rok				10h Mailie	a Addres	e (Street	Helen W		er City	or Town State Zin	Codel
Ma	d 2 s ith an 27 is i				ood/Husbar	nd		_		, Accide		215		, 6000)
Je,	of Hea		20a. Method of Dis				Place of Dispo	sition (Na	me of		Date	20c. L	ocation - City or T	own, State
imo	Page ment c ent: If ury or		1 □ Buria1 2 4 □ Donation		3 □Removal from Specify)	n State	ountry	Side	Crem	atory Oc				
Baltimore,	permit. Departimporti		21. Signature of Fi	urferal Service	Licensee	w				s of Facility New 75, Gran				P.A.
			23a. Part 1. Enter i	the disease, o	r complications that t only one cause on	caused the dea	th. Do not ent	er the mo	de of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final						ander			,	Onset and Death
	/Medical Examiner		resulting in death)		Due to	o (or as a conse						, ,		70
п	Lxammer		Sequentially list co	onditions,	b									
	led isit	ulue	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or	nmediate erlying r injury	₹ Due to	o (or as a conse	quence or):							
	ficate be executed physicien and s the burial-transit	Examiner	that initiated event resulting in death)	S	c	o (or as a conse	quence of):							
68760,	sicier burie	alE												
687		edical			u									
Вох	death cert e attending id for use a	M/u	IF FEMALE: 23b. Was deceder	nt pregnant		utcome of pregr		Testopia	oregnancy				23d. Date of deliv	
		Physician/M	in the past 12 1 Tes 2	No		gnant at time of		Other (s					Month	Day Year
P.0	at the	پر چ	9 🗆 Unknowr				-							
	requires that the een signed by th nould be detache	P S	Part II. Other signi	ficant condit	ions contributing to	_	sulting in the u	nderlying	cause giv	en in Part I.				the cause of death? bably 4 Unknown
ord	equi	ted		cup	4 se we	<u> </u>						Yes 2		bably 4 Elolikilowii
of Vital Records,	law las b	Completed									24a. Was	psy	prior to co	opsy findings available ompletion of cause of
H	The lav	Co									1 ☐ Yes	ormed? 2 D No	death? 1 ☐ Yes	2□ No
Vita	sician: Th certificate rector, pag	Be	25. Was case refe examiner?	1	Hospital:					26. Place of Dea	ith (Check only	one)		
of	Phys this al dir	2	1 Tes 2		1	Inpatient 2	28b. Time o			4 🗆 Nursing n	ome 5 Res		6 Other (Spec	ify)
u	ding h. After funer	Floa	1 Natural	5 🗌 Pendi	ing (Mo	e of Injury onth, Day Year)	Injury	м.	28c. Injury Work	Yes 2□No	280. Describe	now inju	iy occurred	
Division	deatl deatl ctor: y the	fica	2 Accident 3 Suicide	6 ☐ Could	not be	ce of Injury - At	home, farm, st				28f. Location	(Street a	nd Number or Rui	ral Route Number,
5	s effer	Certification:	4 🗌 Homicide	deten	buil	lding, etc. (Spec	cify)		,		City or To	wn, Stat	9)	
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one)		ng Physician: To the									
	o the o the omple	Mec	29b. Signature and	title of certifi	er and ma			25	9c. Licens	e number		29d. Da	ate signed (Month	. Day, Year)
	⊬≯⊬ŏ		> /	XH	//		my		D-23	979		1	0,49	
		10	30. Name and and	tress of person	who completed ca	use of death (Ite	m 23a) (Type	Print)	<i>D</i> −23	פוט			().	
		12			lski, 311				nd.	MD 21550)			
	Sta	ate	31. Date filed (Mo) 32.	Registrar's Sign			1					

(First, Middle, La				Certific	cate of	Death		R	eg. No.	20	09	3497
	ast)						2.	Date of Deat	th Day	,	Year	3. Time of Death
E. Sarle							10	0/14/20	009			1:23 A N
not institution, giv		_				or Location of Dea	ath			County o		
General mber 6.8			yrs. last birtl		r 1 n nder 1 Year	If Under 24 Hi	rs. 8	. Date of Birth	1	rces		hplace (State or Foreig
	1 🔀 M 2□ F	68		rs. Mor	ths Days	Hours Mi	n.	(Month, Day, 7 / 10 / 19	Year)	Р		uintry)
Decedent			0: -					., ., .,				10d. Inside City Limits
10b. County			. City, Town									1 X Yes 2 □ No
Worceste	<u>er</u>	00	cean C		. Zip Code				0a. Citiz	en of Wh	nat Co	untry?
Sť. apt	115				1842			1	JSA			
Je. ape	12. Was Dec	edent Ever i	in U.S.	13. Was D	ecedent of I	Hispanic Origin?	(Specif	ly Yes or No-				rican Indian,
d 2□ Married	Armed For 1 X Yes If Yes, Gi	2 □ No			specify Cub	Specify:	erto Hic	can, etc.)		Black, Specify:	, White ฟhi	
Divorced	Year or D	Dates:										
 Decedent's E y only highest grade 	ducation ade completed)		16a.	Decedent's (Give kind o life DO NO	Usual Occu f work done Tuse retire	pation during most of w d)	orking	43	16b. Kin	d of Bus	iness/l	Industry
dary (0-12)	College (1-4or 5+)	1	ail ma					reta	il s	ale	es.
irst, Middle, Last	!)		1.00			18. Mother's N	ame (F					
dward Sa	arley					Beatri	ce :	Smith				
me/Relationship			19b.	Mailing Add	Iress (Stree	t and Number or	Rural F	Route Numbe	r, City or	Town, S	State, Z	Zip Code)
<u>le Laut</u>	ieri					Wharf Ro						
sition Cremation 3	☐ <u>B</u> emoval from	State _	^	r, crematory	or other pla		Date					Town, State
Other (Speci	_f ⁄Łntombr	ment (Calvar							s PA		
al Service Lice	see	,				ess of Facility TI um St Bei					IH	lome
e disease, or con	polications that	caused the	death. Do n							1		Approximate Interval Between
e disease, or com tfailure. List only Final	-		ma 1	mout	- Asil	une					13	Onset and Death
-	a. Due to	nges7	sequence o	f):	IMI	WE						_
dia:	h	9										
ditions, ying	Due to	(or as a cor	se quence o	f):							- 9	
ijury ast	C. Due to	/		4).								
	Due to	(or as a cor	nsequence o	1):								
	d											
prognant	23c. If yes, ou								2	3d. Date	of del	livery
	4 ☐ Preg	birth 2□ jnant at time			pic pregnan er (s <i>pecify)</i> _	су				Mon		Day Year
nonths?	9 🗌 Unki	nown										
nonths?		leath but not	resulting in	the underly	ing cause gi	ven in Part I.						the cause of death?
nonths? No	contributing to d	n					_	1 🗆 Y	es 2	JNo 3	3∐ Pr	robably 4 \ Unknow
nonths? No	contributing to d	2										topsy findings availabl
nonths? No	contributing to d	2					_	24a. Was a autops	SV	l pr	rior to o	completion of cause of
nonths? No	contributing to d	2					-	autops perfori	SV	pr de	rior to o eath?	completion of cause of
ant conditions of the second s	failure Hospital:	0				26. Place of D		autops perform 1 🗆 Yes Check only on	med? 2 No	pr de 1	rior to death? □Yes	completion of cause of
ant conditions of the second s	Hospital:		2	·	DOA	her: 4 🗆 Nursing	Home	autops perform 1 □ Yes Check only on 5 □ Reside	med? 2 No 2 No e) ence 6	pr de 1 l	rior to death? Yes r (Spe	completion of cause of
cant conditions	Hospital: 28a. Date (Mor		28b. T	·	28c. Inju	her: 4 Nursing	Home	autops perform 1 🗆 Yes Check only on	med? 2 No 2 No e) ence 6	pr de 1 l	rior to death? Yes r (Spe	completion of cause of
investigatio 6 ☐ Could not b	Hospital: 28a. Date (Morning) 28e. Place	of Injury oth, Day, Yea	28b. T In	ime of jury M	28c. Inju Wo	her: 4 Nursing iry at rk?	Home 28	autops perform 1 □ Yes Check only on 5 □ Reside d. Describe he	med? 2 No ne) ence 6 ow injury	Other	rior to death? Yes	completion of cause of
cant conditions of the conditi	Hospital: 28a. Date (Morning) 28e. Place	of Injury oth, Day, Yea	28b. T In	ime of jury M	28c. Inju Wo	her: 4 Nursing iry at rk?	Home 28	autops perfori 1 □ Yes Check only on 5 □ Reside	med? 2 No ne) ence 6 ow injury	Other	rior to death? Yes	completion of cause of 2 □ No

State
Registrar

Allautic General Hospital, 9733 Healthway Drive, Berlin, MD 21811

32. Registrar's Signature

Samue S. Spaces

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Town Egword Mo, Allastic Geveral H

31. Date filed (Monte, Pay, Year)

16 2009

32 Registrar's Signature

33 Agents Signature

09-08173 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Havangela Scott State of Maryland / Department of Health and Mental Hygiene 2009 34972 1- For State Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 21, 2009 1338 hrs Medical Examiner Havangela Scott 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cheverly Prince George's Prince George's Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months °Mash.,D.C. Director 2X F 46 04/16/1963 578-92-9131 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No Capitol Heights notified at once. Prince George's death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5402 Ingleboro Court 20743 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes 2x No Black permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. In prortant: If item 27 is marked other than "matural", o injury or other traumatic event, the Medical Examiner." 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 x No specify: Specify þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 2 yrs Budget Analyst FEMA 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Pittman ,Jr. Barbara Ann Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B Michael Scott/Husband 5402 Ingleboro Ct., Capitol Heights, Md. 20743 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Maryland Nat'l. Hark 10/31/09 Laurel Maryland Other Specify: Mem. 21. Signature of Funeral Service Licensee 22. Name and Address of nd Address of Facility H.S. Washington & Sons Co., Inc. au 1 acti W. 23a. Part I. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac biventricular dilatation associated with Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): moderate coronary atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed X UNPENDED AMENDED e attending physician for use as the burial 23a,27,perME, G897 11/23/09 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed b 2 should be detac 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✔ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Division of Vital æ examiner? Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred XNatural n 24 hours after death.

re Funeral Director: A detely filled in by the fur 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 22, 2009

CR

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

Assistant Medical Examiner

32. Registrar's Signature

OCME

OCME

				Please	Type or Prin							_	ble.		
			For State Registrar		State of Ma	arylan		artment of <i>rtificate of</i>		and Mental H	ygien Reg. N	') ()	09	34	971
	Dhusisi		1. Decedent's Name	e (First, Middle, La	ast)					2. Date of D	eath	ay	Year	3. Time o	of Death
	Physicia /Medic		Joseph	Char1	es Tris	zczuł	k, Sr.			Octobe				5:57	a M
	Examin		4a. Facility Name (I	lf not institution, gl	ve street and number)			4b. City, Town,	or Location o	of Death	4	c. County	of Death	-	
475			St. Mary	's Hospi				1	ardtow				Mary		
ı	Funeral Director		5. Social Security N 203-09-2	2157	Sex 7. Ag 1 🔀 M 2 🗆 F	e (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Date of B (Month, I	irth Day, Year 1919)		lace (State stry) sylvar	
	and w		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation					1	0d. Inside 0	City Limits
	e Maryl Ba-f sho	Director	Maryland	St. Ma	ry's		o11ywo								s 2XMNo
	or 28	<u>Dir</u>	10e, Street and Nur	mber				10f. Zip Code			10g. C	itizen of V	Vhat Coun	try?	
	ath w		44613 C	larkes L	anding Roa			206				US	A		
	er dez	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori	gin? (Specify Yes or N n, Puerto Rican, etc.)	lo-	14. Raci	e - Americ k, White, e	an Indian, etc.	
2-002p	hours after death with the Maryland tural", or items 23a or 28a-f show al Exameter must be notified at	ρ	1 ☐ Never Marri 3 ☐ Widowed	ied 2 X Married 4 □ Divorced	1 ∏Yes 2 🔯 I If Yes, Give Year or Dates:	No		1∐Yes 2 1 ∑No				Specify		ite	
7 2	hin 72 h e. an "natu	Completed	(Spec	15. Decedent's E	ducation ade completed) College (1-4or 5	.±)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most ed)	t of working	16b.	Kind of Bu	isiness/Ind	dustry	
_ V	d with	No.	12	, , , , , , , , , , , , , , , , , , ,	- College (1-40) b		Prof	essional	Drive	er	Au	to De	ealer	ship	
	al Hy doth vent	Be (17. Father's Name	(First, Middle, Las	t)				18. Mothe	er's Name (First, Middl	e, Maide	n Surnam	e)		
yıa	Ment Ment arked atic	P	Michae:	1 Tr	Lszczuk				Agı	nes Le	chor	obicz	Z		
ā	2 sho		19a. Informant's Na	•			1			er or Rural Route Num		•	. ,	,	
≥ 1	and fealth m 27 her to				/Daughter					ding Rd.,					6
altimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Experiment must be netified at once.				Removal from State	Imn	Place of Dispo cemetery, crei naculat	osition (Name of matory or other place te Heart	fary 1	Date 10/22/2009			City or To on Pa	,	D
ספור	permit. Departr Importa any inju		21. Sig	N. Brinst	field, Jr.		22	2. Name and Addr	ess of Facilit	Brinsfield Rd., Leo					
ı					nplications that caused one cause on each lir									Approxima Interval Be	ate
	Physician		Immediate Cause (disease or conditio	(Final	one cause on each iir	1e.	Ar	rhatha					10	Onset and	Death
	/Medical		resulting in death)	-	Due to (or as	a consequ	uence of):						-	<u>√.~+</u>	<u></u>
	Examiner		Sequentially list cor	nditions	b										
	po tis	ne	if any, leading to im Cause (Disease or that initiated events	mediate	Due to (or as	a consequ	uence of):						- 5		
	ecute and -trans	Examine	Cause (Disease or that initiated events resulting in death) L	injury	c										
Ď,			rooding in doday b	-431	Due to (or as	a consequ	uence of):								
0	cate physi the t	gi			d										
200	death certificate be executed e aftending physician and d for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outcome	2 Fetal	ideath 3	⊒ Ectopic pregnan	су			23d. Dat	e of delive	ery Day	Year
5	he de the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant at 9 ☐ Unknown	t time of d	leath 5	Other (specify)				IVIO		Luy	.00

To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact

State

Medical Certification: To Be Completed by

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Tes 2 No

27. Manner of De ath 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🔲 Inpatient

28a. Date of Injury (Month, Day, Year)

29c. License number

28c. Injury at Work?

1 ☐Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No

1 ☐ Yes 2 ☐ No 3 ☐ Probably

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Grzepzeusk: P.G. B.

31. Date filed (Month, Day, Year) OCT 20

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** Margaret Magdalene Bennett 4:40 p M Taylor 22, 2009 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 49343 Bennett Drive St. Mary's Ridge 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖾 F Days Hours 212-22-2777 Director 97 Maryland 01/24/1912 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating the principled at 1 ☐ Yes 2X No Directo St. Mary's Ridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20680 USA 49343 Bennett Drive Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2【No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify þ Specify: **Black** 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Teachers Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. Lee Robert 0. Bennett Mary ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delois Barnes/Goddaughter 3295 Westdale Ct., Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of It
Important: If ite
any Injury or ot 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 10/31/2009 St. Peter Claver 4 ☐ Donation 5 ☐ Other (Specify) St. Inigoes, MD Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ixhemic **Physician** /Medical Due to (or as a consequence of): Examiner myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner oulmonay. and Due (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the. asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the the 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **2**00 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10123104 D0068667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10,10 Maryam Meratee, M.D. 24435 Mervell Dean Road, Hollywood, MD 20636 31. Date filed (Month) 32. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34976 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October ^{Day} 3 2009 **Physician** 10:30 AM MARY LOUISE TIMMONS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BERLIN NURSING & REHABILITATION CTR. BERLIN WORCESTER 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F 80 218-24-4002 Director FEB. 1929 MARÝLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 BROAD ST., APT. Funeral 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🛣 No Specify: ģ Specify: 3 XWidowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 COOK RESTAURANT 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ALBERT HENRY GRAVENOR 2 MADA L. COOPER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) immons Itimore, M SHERYL M. MILLER/FRIEND 111 BROAD ST., BERLIN, MARYLAND 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation RIVERSIDE CEMETERY 10/16/09 BERLIN, MARYLAND 21. Signature of an ral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 unde Part I. Enter the diseas I, or complications that caused the shock, or heart failure. List only one cause in each lift. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death lmonary Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifler Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEALTHWAY DRIVE, BERLIN, MD 21811 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 34977 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Geneva Ward Turner Ctober 02 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 14,1927 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Hours Director 212-24-3026 82 Yrs Maryland Sept. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f Maryland Washington Hagerstown___ 1 🗌 Yes 2 🔀 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 123 Southern Oak Drive 21740 USA items ? within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ò δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" Completed Specify: 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Sewing Be be filed √ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Franklin E. Doyle Geneva Ward Leather permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Turner (Husband) 123 Southern Oak Dr. Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State *October* Smithsburg, Maryland Smithsburg Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 20, 2009 Signature of Funeral Service Licensee J.L. Davis Funeral Home 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ meumomo disease or condition Medical resulting in death) Die to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury equence of Due to (or as a con-To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

63	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
ın Paul Upshur	State of Maryland / Department of Health and Mental Hygiene	200
1- For State	Certificate of Death Reg. No.	200

an Paul U		1- For State Certification Cer	icale of	Death		R	eg. No.	200	
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Dea Month	Day \	/ear	3. Time of Death 2112 hrs
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		4a. Facility Name (if not institution, give street and number)	41	b. City, Town, or Cheverely	Location of Deat	:n		ty of Death e George's	S
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ı	Physici	an	1. Decedent's Name (First, Middle, Last)	AICE NEW	7		2. Date of Death Month		3. Time of Death
	/Medio	al	ALAN JUAN VI	NLENI	T., a, -		10	2 2009	145+ pm
n. ph	Examir	er	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospi	.tal	Takoma	Location of Death Park		4c. County of Death Montgo	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 14-52-6879 6. Sex 7. Ag	e (In yrs. last birthday 60 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, April 1	9. Birth Cou 3. 1949 M	nplace (State or Foreign intry) ichigan
	TO .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L					
	Maryla f sho	ō	Maryland Montgomery	,	oma Park				10d. Inside City Limits 12 Yes 2 No
	r 28a	Director	10e. Street and Number	Ida	10f. Zip Code		10	g. Citizen of What Cou	intry?
	23a c		8111 Sligo Creek Parkway		20912			USA	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaniner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 □ Hryes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 27☐ No	ispanic Origin? (Spec n, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify:	
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occup e kind of work done o	lurina most of working	, 1	6b. Kind of Business/li	ndustry
72	s should be filed within and Mental Hygiene. is marked other than sumatic event, Inc. M.	dmo	Elementary/Secondary (0-12) College (1-4or 5	·+)	DO NOT use retired)	I	Education	
g	e filed al Hyg I other vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (
ylaı	2 should be and Mental is marked or raumatic even	으	John Vincent				Maude E		
, Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print) Paula Eileen Vincent/Wife					City or Town, State, Z Cakoma Parl	ip Code) K, MD 20912
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp Pine Grov Kind Grov	osition (Name of Beat Contine relaced Te Cemeter	Octobe 2009	er 16	oc. Location - City or Treeland, N	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	Í	rancis J. 500 Univer	collins Facility ins Facility Blvd.	Tuneral	Home Inc.	ng, MD 20901
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Age.	Physician / /Medical		resulting in death)	MOCYSTI	is cari	nii Phei	moni	9	
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Records, F	w requires that s been signed b should be deta	by P	Part II. Other significant conditions contributing to death bu	ut not resulting in the i	underlying cause give	en in Part I.	1	acco use contribute to c 2 ☐ No 3 ☐ Pro	the cause of death?
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Vita	s certific lirector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 1 No	nt 2 ☐ ER/Outpatie	ont 3 🗆 DOA Othe	26. Place of Death (
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Division of	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fo	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc.	ury - At home, farm, st c. (Specify)		/es 2 □ No	if. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospit within 24 hours To the Funera completely fille	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner sta	f examination and/or i	th occurred at the tin nvestigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the car d at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	-	29c. License	4	29	d. Date signed (Month	, Day, Year)
	10	}	· Meur			64024	/	0/14/2009	1
			30. Name and address of person who completed cause of display. ANNA LH 31. Date filed (Month, Day, Year) OCT 19 2009 Length	eath (Item 23a) (Type, CHTCHI A	Print), VA, A	1.0.	1600 (Takor	arroll A	venue , MD20912
	Sta Registra		31. Date filed (Month, Day, Year) OCT 19 2009 Registra	s Signature	Hed.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 9 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Leila Ann VALK October 17, 2009 7:34 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec ... 8. Date of Birth Dec ... 1312, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Months 79 Director 102-22-4781 New York Usual Residence of Decedent 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sho Calabasas California Los Angeles Director 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4738 Park Granada 91302 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: <u>۾</u> Specify: Specify: white 3 Widowed 4 Divorced Completed th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Belle Cohen Herbert Cooper ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route, Number, City pr Town, State, Zip 1936 New Hampshire Ave., NW, Washington, 20009 t of Health Amy Stromberg, Daughter item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department o Important: If i any Injury or once. ± 5 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 ☐ Other (Specify) Pleasant Cemetery 10/20/09 Mt Hawthorne, NY 21. Signature of Funeral Service Lice see TO PETTISKY SHEBTEW Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) <u>Arteriosclerotic Heart Disease</u> /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of): $e_1 | \alpha \bigvee \alpha \bigvee_{i \in [0,1]} | \beta \bigvee_{i \in [0,1]} |$ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performet/? Yes 2 No 1 ☐ Yes 2 ☐ No : After this certifice funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 💢 Natural 5 Pending investigation o the Hospital or Attendin ithin 24 hours after death. • The Funeral Director: Af ompletely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D 055480 October 18, 2009 WIL 30. Name and address of person who, ompleted cause of death (Item 23a) (Type, Print)

Brendan James (a) mody, M.D., 8600 01d Georgetown Road, Bethesda, MD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

22. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Ω Ω Q

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	Physician	Darej kaar.		meyer			2. Dete of Deeth	1 Dey 200		3. Time of Death 0736
	/Medical Examiner	A. F. die Alexander de la constitución de				4b. City, Town, or		4c. County of		
		111 Fooks A				Presto		Caro		
	Funeral Director	5. Social Security Number 213-58-8304 Usuel Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☐xF	Age (In yrs. last birth	Months Dev		8. Date of Birth (Month, Dey, Apr. 23	, 1949	9. Birthpled Country Dist. (ce (Stete or Foreign of Columbia
	Mend Mend	10a. State 10b. County	,	10c. City, Town	or Location				100	f. Inside City Limits
	e Mar	MD Caro	line		Prest	on				ty∏Yes 2□No
	vith th	10e. Street end Number			10f. Zip Code		10	g. Citizen of W		
	ne 234	111 Fooks Av	Venue	ent Ever in U.S.		1655 Hispenic Origin? (S	pecify Yes or No-	Unite	- American	
0200-91212	uld be filled within 72 hours after deeth with the Maryland Mentel Hyglene. riked other than "naturel", or items 23a or 28a-f show tite event, the Medical Examinat must be notified at To Be Completed by Finneral Director	1 Never Married 2 X Mar 3 Widowed 4 Divorced	ried Armed Force	es? F No	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		o Rican, etc.)	Specify:	White, etc. Whi	
7	72 ho	15. Deceder (Specify only highe	nt's Education est grede completed)	16a. E	ecedent's Usuel Occ Give kind of work don ife. DO NOT use retii	upetion e during most of wor	rking 1	6b. Kind of Bus	si <i>n</i> ess/Indu	stry
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	e filed well Hygier other the	17. Father's Neme (First, Middle,	Lest)			18. Mother's Nar	ne (First, Middle, M			
<u>Ya</u>	Mentel Mentel irked o	Joseph Fran	cis Stant	on		Daisy F	auline	St. C1	air	
maryland	2 sho	19a. Informant's Name/Relations			Mailing Address (Street				State, Zip C	ode)
	1 and Heelth em 27 rther tr	Gary E. Waltem	eyer/ Spous		1 Fooks Av Disposition (Name of crematory or other pi			21655 0c. Location - 0	City or Town	n. State
saltimore,	t. Peges rment of I tant: If ite	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)		Sh. Vetera	ns Cem.	10/15/09 H	urlock,	Mary	land
g	Depari Impor	21. Signature of Funeral Service	t. Eskan	,	216 N. Ma:	ress of Fecility Francisco				
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scords,	The law requires that the death cerbate has been signed by the attendin page 2 should be datached for use Completed by Physician/N						24a. Wes an perform	autopsy ed?	availa	a autopsy findings able prior to pletion of cause ath?
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	To the Hospital or Attending Physician: The law within 24 burus aftar deeth. To the Funerel Director After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compi	1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pendin 2 Accident investig			ne of 28c. Injury		ome 5 Describe how			
	rs after deeth. Is after deeth. In Director: After ted in by the funer. Certification:	2 Accident investig 3 Suicide 6 Could t 4 Homicide determ	not be 28e. Plece of	Injury - At home, farm etc. (Specify)	, street, factory, office	9	28f. Location (Str. City or Town,		r or Rurel F	Route Number,
	he Hospita in 24 hours he Funere pletely fille edical (29a. Certifier 1 Certifyin (Check only one) 2 Medicat	g Physician: To the be Examiner: On the basis and manner	of exemination and/o	leath occurred et the or investigation, in my	time, dete and place opinion, death occu	, and due to the ce rred at the time, da	use(s) and man te and place, a	ner as statend due to the	ed. ne cause(s)
	Within To th Comp	29b. Signature end title of certifier	110			se number		d. Date signed		
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		David H. S.	who completed cause o		eal Dri	39887 ve #30	1 84	ston	Md	
i	State Registrar	31. Date filed (Mog) (Tay, Year)	2009 32. Regi	strer's Signeture	base					

O DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month 1441 AN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/13/1930 **Funeral** 9. Birthplace (State or Foreign Months 1 □ M 2 🗹 F Days Hours 577-36-7886 78 Washington,D.C. Director Usual Residence of Decedent the Maryland r 28a-f show 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐Yes 21 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Madical Examinat must be 1 10 Oak Court 21401 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 ∏ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 Specify.White 1 □ Yes 2 No Completed by 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel County Office Elementary/Secondary (0-12) College (1-4or 5+) Clerk of Assessment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Richter Martha Mitchell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Dindino/Daughter 350 Terrace Drive, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/16/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home HIMA 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 🗌 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1/1 Natural Housi 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifie 2 29c. License number Name and address of person pleted cause of death (Item 23a) (Type, Print) 441 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State nct 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	partment of H <i>ertificate of</i>	lealth a <i>Death</i>	nd Mental Hy	giene2 Reg. No.	009	34983
	Physici /Medi		1. Decedent's Name (First, Middle, Last MARGAIZET	Cath	erine	Wal	15	2. Date of De Month	Day	2009	3. Time of Death A
	Examir	ner	4a. Facility Name (If not institution, give	ROAD)		ANTS	SUILLE	4c. Cou	nty of Death	-877
l	Funeral Director		5. Social Security Number 217–30–1326 Usual Residence of Decedent	7. Age	e (In yrs. last birthda 76 Yrs	Months Davs	If Under 24 Hours	Min. 8. Date of Bir (Month, Date of Late of La	ıy, Year)	9. Birthpli Count Mary	
	Maryland a-f show lied at	tor	10a. State 10b. County MD Garrett		10c. City, Town or					10	d. Inside City Limits 1 □ Yes 2X No
	with the	Funeral Director	10e. Street and Number		GLAIICSVI	10f. Zip Code			10g. Citizen	of What Count	ry?
	death ins 23	eral	5595 Amish Rd.	12. Was Decedent E	Ever in U.S. 1	21536 3. Was Decedent of F	lispanic Origi	in? (Specify Yes or No	USA 14 F	Race - America	ın İndian
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	by Fur	1 □ Never Married 2 □ Married 3 【 Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 16 N If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 No	Specify:	in? (Specify Yes or No Puerto Rican, etc.)	Spe	Black, White, et	ic.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Madical Examiner must be notified at once.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation completed) College (1-4or 5	+) (Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired	durina most c	of working		f Business/Indu	ustry
d 2	filed w Hygie ther ti	ပ္သ	17. Father's Name (First, Middle, Last)	1	L.	P.N.	18 Mother's	s Name (First, Middle,		lth Car	'e
Maryland	Mental Mental arked o	To Be	Paul Krause					eah McKenz		iame)	
Mar	nd 2 sho alth and 27 is m ir traum	ê'r	19a. Informant's Name/Relationship (Ty Julie Swarey/Niece	oe. Print)				or Rural Route Numb Naynesburg		vn, State, Zip (14688	Code)
Baltimore,	Pages 1 ar lent of Hez nt: If item ry or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dis	position (Name of rematory or other place	ee)	Date t. 11, 200	20c. Locatio	n - City or Tow	
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licens	6 1		22. Name and Addre	ss of Facility	Newman Fur	neral E		
	Iticate be executed Medical Examiner bhysician and sthe burial-transit	edical Examiner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, be fing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	3		21 MVR	iest,		Approximate inferval Between Onset and Death
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/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?				26. Place of	1 ☐ Yes f Death (Check only o		TLJ165 Z	
of	Physi this o	၉	1 Yes 2 No H		nt 2 ER/Outpati		4 LI Nurs	ing Home 5 Resid			
0	nding th. : After e funer	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)		Work	/at ? Yes 2∐No	28d. Describe h	ow injury occ	urred	
Division of Vital	Io the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: completely filled in by the funeral director, p	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm, s (Specify)			28f. Location (S City or Tow	Street and Nui in, State)	mber or Rural i	Route Number,
;	n 24 hour	edical	29a. Certifier (Check only one) Check only one) Check only one)	ician: To the best or er: On the basis of and manner stat	examination and/or	ath occurred at the tin investigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and date and plac	manner as sta e, and due to t	ited. he cause(s)
	Vithi Vithi Comp	Me	29b. Signature and title of certifier Paul Dans	mel	0	29c. License	e number	4	29d. Date sign	ned (Month, Da	ay, Year)
		6	30. Name and address of person who co	npleted cause of de	ath (Item 23a) (Type	Print)	200	Dr 10-1	11	QU	11000
	Stat	_	31. Date filed (Month, Day, Year)	32. R gistrar	's Signature	boll !	47	vi Ua	wan	U Ji	7 7 63 0

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Year Edna /Medical October 2009 11:45A Mahale Wolf 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dennett Road Manor Oakland Garrett Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours **Director** <u>213-64-8939</u> 9/11/1914 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location id other than "natural", or items 23a or 28a-f show event, the Medical Examination state motified at 10d. Inside City Limits Director 1 ∐ Yes 21√2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 Norris Welch RDFuneral 21550 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√☐ No \$ Specify: 3X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic events." 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker ${\tt Home}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Silas ပ္ Platter Bertha Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Wolf/Son <u>3129 Pleasant Valley RD, </u> Baltimore, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Mem.Gardens 10/7/09 Oakland, MD 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signatura of Funeral Service Licensee Second St., Oakland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1∐Yes 2₽1No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No After this c funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature an title of certifier 29d. Date signed (Month, Day, Year) my 30. Name and address of person w completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

9

4NSK1

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 19 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Betty Jane Wildesen October 3:15 P.[™] 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oakland Nursing & Rehab Center 0akland Garrett 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 21/2 F Months 212-24-1970 9, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYPes 2 □ No Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 E. Alder Street 21550 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify. 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Umber Wellington Brav Mary Ellen O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald W. Wildesen, Son 110 O'Brien Street, Mtn. Lake Park, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10/13/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Memorial Gardens Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 atherine 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

ettending physicien and for usa as the burial-transit

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certificate hes

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Physiclan/Medical

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Completed

Be

Certification;

The law requires that the death certificate ba exacuted

Division of Vital Records, P.O. Box 68760

permit. Pagas 1 and 2 should be filad w Department of Health and Mental Hygier Important: if itam 27 is marked other th any njury or other traumatic event, ITA 0DGS.

Physician

Funeral

Director

r then "natural", or items 23s or 28s-f show the Modical Examiner must be notified at

Pagas 1 and 2 should be filad within 72 hours efter death with the Maryland nent of Heatth and Mental Hygiene. Int: If Itam 27 is marked other then "natural", or Items 23s or 28s-1 show

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be ဂ

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

a.	ause on each line.	Interval Between Onset and Death
b. –	Due to (or as a consequence of): Due to (or as a consequence of):	46413
c.	Due to (or as a consequence of):	
d		

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

1 Natural

2 Accident

3 Suicide

4 | Homicide

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 2 Fetal death 4☐Pregnant at time of death 9 Unknown

3 ☐Ectopic pregnancy 5 Other (specify)

3☐ DOA

Month Day

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Inpatient

2 ₽No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

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h /C	heck	only i	one)	
		70		• •

26. Place of Deatl Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 | Pending investigation 1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Hospital:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

74

801

29c. License numbe

KLGI

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ken R. Buczynski, MD

State Registrar

U 32. Pagistrar's Signature

E

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Wilson Davis Warren OCTOBER 14 2009 3:20P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Berlin Nursing Home</u> Berlin Worcester If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/18/1919 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2 □ F 89 MD **Director** 218-12-1993 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Maryland Evantine, must be notified at any injury or other traumatic event, I'm Maryland Evantine, must be notified at any injury or other traumatic event, I'm Maryland Evantine, must be notified at any once. 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Y Yes 2 □ No Director MD Worcester Berlin 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 5 Powellton Avenue 21811 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1√Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk <u>dept. store</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude E. Warren ပ Ethel Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Richard Warren (son)</u> <u>701 Devon Rd Richmond VA 23229</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Buckingham Cemetery 22. Name and Address of Facility The Burbage Funeral Home of Fune al Service Licensee <u>William St Berlin, MD 21811</u> 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 1 ☐Yes 2 ☐No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c_License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St Salisburg Sowas CRNP Rmc State 2009 Registrar

WARREN, WILSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Day Feeser William Wantz 2009 11:00 p^M October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster 1532 Stone Road 8. Date of Birth (Month, Pay, Year) Oct. 16, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 XM 2 □ F 220-24-8931 81 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Department of Health and Mental Hygiene. "Important; or items 23a or 28a-f shou important: if item 27 Is marked other than "natural", or items 23a or 28a-f shou any Injury or other traumatic event, the Medical Examination must be notified at once. 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1532 Stone Rd. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant I frem 27 Is marked other than "natural", or ite 1 Syes 2 No If Yes, Give Year or Dates 1945–1949 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: Ş White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry International Union (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Operating Engineers Operating Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leander C. Wantz Fannie Helen Feeser ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Haines Wantz/Wife 1532 Stone Rd., Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc. 10/15/2009 Hampstead, Maryland 21. Signature of Foreral Service License Pritts Funerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that canned the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final therosclevori Cerdro Vofuler **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hyper tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Yea Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 1 🗌 Yes 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 Ho Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 D Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

Registrar

29a. Certifier

(Check only one)

MINU

29b. Signature and title of certifier

cal

and manner stated.

Stoner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

291

CITACKO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2009

State of Maryland / Department of Health and Mental Hygiene 34988 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Yvonne K. Walker <u>12:11₽™</u> 12,2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17213 Russet Drive George Bowie Prince Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 76 Months Hours Min. 1 □ M 2 🕱 F Director 285-30-6979 04-27-1933 Alabama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinational be notified at Director 1 Yes 2 No MD Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17213 Russet Drive USA 20716 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify: <u>8</u> 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
Master s Deq Elementary/Secondary (0-12) Regional Manager Gov't <u>Federal</u> permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lipiry or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tolley Kennon Rose Marie Davis မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Brown (Son) 17213 Russet Drive Bowie Maryland 20716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 23, 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem Pk Cem Landover Maryland 21. Signatur of Funeral Service License 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St.NW WashDC 23a. Part 1. Enter the disease, or complication that caused the reshock of heart failure. List only one course on each line. Approximate Interval Between Onset and Death Do not entur the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 4Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical as IF FEMALE: for use yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Year ☐ Pregnant at time of death 5 Other (specify) detached 9 I Inknown signed I tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Ves 2 this certificate Division of Vital 2 🗆 No 1 □ Yes 1 □ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) License number 30. Name ar address of person who completed cause of death (Item 23a) (Type State 1 9 2009 Registrar

9-07956		Please Type or Print in Black Indeli	ble Ink. Ensure All Copie	
nk Unk		State of Maryland / Departme	ent of Health and Mental H ate of Death	2003 3430
		Registrar 1. Decedent's Name (First, Middle,Last)	- Death	Reg. No. 2. Date of Death 3. Time of Death
Physic Medical Exam				Month Day Year 1530 hrs October 13, 2009
K		4a. Facility Name (if not institution, give street and number) 7055 Minstral Way	4b. City, Town, or Location of Death Columbia	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		288-72-0554 1 ^X M 2 F 36	Yrs. Months Days Hours Mir	4/15/1973 Columbus, Ohio
ий		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
de how i	Ļ	Maryland Prince George's Laure	1	1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural", or items 23a or 23a-f show any inity or other trannaite event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
the M	ä	9455 Fens Hollow Drive	20723	United States
h with ms 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Salf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- D Rican, etc.) 14. Race - American Indian, Black, White, etc.
r deat	표	X Never Married 2 Married 1 Yes 2 X No	1 Yes 2 No specify:	Specify: Black
rs afte ural",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of	
2 hous	ted		during most of working life. DO NOT use re-	
336 thin 7 ne. • than	Completed	12 2 I	T Specialist	Private
5-0 led wi Hygiei other	ြီ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
121 d be fil ental arked	Be	Billie Williams	Patrici	a Lloyd Rural Route Number, City or Town, State, Zip Code)
D 2 should and M 7 is m	۴			nroe North Carolina 28112
and 2 sealth:		20a. Method of Disposition 20b. Place of	of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
nore ges 1 trof H tr If i		Burial 2 11 Cremation 3 Removal from State	ory or other place)	-23-09 Riverdale, Maryland
Itim iit. Pa artmer ortan	1, 3	4 Donation 5 Other Spegify River 21. Signature of Funeral Service Aicensee		e Funeral Homes, P.A.
Ba Perr Depr Imp		23g/ Part/ Enter the disease, or complications that caused the death. Do no	5538 Marlboro Pik	e Forestville, Maryland 20747
Medica :amîne	aminer	failure. List only or (e cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Narcotic (morphii Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ne) intoxication and	l cocaine use
e executed cian and rial - transi	<u>8</u>	X UNPENDED dAMENDED 23a,27,28a	a-f,perME, g897 11/2	2/09 TT
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and compleably filled in the fineral director near 2 should be described for use set the burial - transit	Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal death 3 Ectopic pregi 5 Other (Specify)	
b.O. Boy that the death ned by the att	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 VUnknown
ords, P.O. w requires that as been signed t	1 -			24a. Was an 24b. Were autopsy findings available
cords law requi has been	blet			autopsy prior to completion of cause of death?
Zec The la	Completed			1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The his certificate director many	Be (25. Was case referred to medical examiner? Hospital: 4 Inception: 2 ER/C	26,Place of Death (Checoutpatient 3 DOA Other Nurs	
F Vit Physic r this		1 ✓ Yes 2 No	Outpatient 3 DOA Outlet 4 Nurself Ime of Injury 28c. Injury at Work?	sing Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred
ion of tending Pheath. tor: After the funeral	Ë	1 Natural (Month, Day, Year)	1 Voc. 2 V No.	unk
ivision or Atten after death Director:	cat	2 Accident Investigation 28e, Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number of Rural Route Number, City or Town, State) 1055 Minstral way
Divisipital or At ours after deral Direct	Certification:	Suicide 6 X Could not be determined (Specify) Hotel		#213 Columbia, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
To To	Se	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Quil. 12.	O.C.M.E.	October 14, 2009
		30. Name and address of person who completed cause of death (Item 23a)		
12			Penn Street, Baltimore, MD 212	01
	State			
Regi	stra	OUI & TEUS CENTURE 10. 19		

Billic Daviell Williams III

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** October Blanche Marcella Wingler 0735AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Manor Care of Ruxton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🗙 F 214-12-0385 91 Oct. 4, 1918 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show at a or 28a-f shot be notified a MD Baltimore Towson 1 ☐ Yes 2 No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21204 7001 North Charles St. items 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛛 No Specify: Specify: White Ď 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry raumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) oe filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Church General Labor 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I Alan Leroy Cofiell Goldie May Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a.
Important: If item 27 is 1.
any injury or other Propose. 17416 Pretty Boy Dam Rd., Parkton, MD 21120 Allison Hilse, Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Jessup United
Methodist Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Sparks, MD 21152 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner uronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran and Due to (or as a consequence of): aftending physician for use as the burial pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Month Vear in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☑ No the detached 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy performed? /es 2 No page certificate 1□ Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۴ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Certification: 1 Natural 2 Accident Iniury 1 ☐ Yes 2 ☐ No Hospital or Attendi Hours after death. Tuneral Director: A death. filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of perso, who completed cause of death (tem 23a) (Type, Print) Bellona Lane #216 Towson 8415 MD 31. Date filed (Month, Day, Year) Hegistrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thornton Francis White, Jr. 0231 AM October 200 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) Country) On IO Director 457-32-4140 81 1927 Nov. Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Washington Boonsboro 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 20837 Keadle Road 21713 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. was Decedent Ever Armed Forces? 1 Yes 2 No If Yes. Give 14. Race - American Indian, 1944 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1969 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3

Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Communications U.S. Government 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever Hazel K. Goodall pe Thornton F. White, Sr. permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thornton F. White III (Son) P.O. Box 174 Sharpsburg, Maryland 21782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 Burial 2 X Cremation 3 Removal from State October Smithsburg Crematory Smithsburg, Maryland 4 Donation 5 Other (Specify) 20, 2009 Signature of Funeral Service Licensee J.L.Davis Funeral Home 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hemispheric inchemic oreleso vas arter disease or condition resulting in death) Medical (or as a consequence of) Examiner Securitistly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Dial use as the burial-transi and Due to (or as a consequence of): that initiated events resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year be detached the 9 Unknown 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate Yes 2X No 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tes 2 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Tes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hounded the soun Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year) 0CT 3 0 2009

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completed cause of death (Item 23a) (Type, Print)

·			partment of Health and N ertificate of Death	lental Hygier	7 8 8 7	34993					
Physic /Med		1. Decedent's Name (First, Middle, Last) CYRUS E WOLF		2. Date of Death October	Day 4, 2000	3. Time of Death					
Exami		4a. Facility Name (If not institution, give street and number) Fahrney-Keedy Home 5. Social Security Number 6. Sex 7. Age (in yrs. last birthda	4b. City, Town, or Location of Death Boonsboro		4c. County of Dea Washing	gton					
Funeral Director		5. Social Security Number 214-34-2268 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 87 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 6, 1	<i>ar)</i> Co	thplace (State or Foreign ountry) cyland					
Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Maryland Frederick Smiths				10d. Inside City Limits 1 ☐ Yes 2X No					
th with the 23a or 28	Funeral Director	10e. Street and Number 12826 Loy Wolfe Road	10f. Zip Code 21783	10g.	Citizen of What Co	untry?					
Idryland Z IZ IS-UU36 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Marical Experient must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spull Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.					
Z I Z I 3-UU36 d within 72 hours aft giene. r than "natural", or real Medical Expiri	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fai	Kind of Business/								
yiand 2 buld be filed Mental Hyg arked other atic event, 1	To Be Co	17. Father's Name (First, Middle, Last) Loy Nelson Wolf		e (First, Middle, Maid e Florenc	len Surname)						
IOre, INIALYIE ges 1 and 2 should tt of Heatth and Mer If item 27 is marke or other traumatic	Ĕ	19a. Informant's Name/Relationship (Type. Print) 19b. Ma Dale L. Wolf/son 1350	iling Address (Street and Number or Rura 6 Wolfsville Road,	al Route Number, Cit	y or Town, State, 2	Zip Code)					
Dallinore, IVI, permit. Pages 1 and 2 Department of Health & Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition 20b. Place of Dis		Date 20c.	Location - City or	Town, State					
Dall permit. Departr Importa any Inju			22. Name and Address of Facility Ricketts Funeral Ho		ain Stre						
Physician	8/ 1	Ricketts Funeral Home Myersville, MD 21773 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition									
/Medical Examiner		Due to (or as a consequence of): Sequentially list conditions, b.	Renal Disca	5 -							
cate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to kinnediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. 200 to (or as a consequence of): c. Due to (or as a consequence of):									
ificate be exe physician as the burial-	dical	d									
The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	23d. Date of del Month	delivery Day Year							
w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the		use contribute to the cause of death?							
ician: The law rector, page 2 sh	Completed			24a. Was an autopsy performed? 1 □ Yes 2 2	prior to death?	topsy findings available completion of cause of 2 □ No					
Physician: r this certificaral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	26. Place of Death								
Attending Physician: r death. ector: After this certific by the funeral director, I	ation: To	27. Manner of Death 12 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	of 28c. Injury at 2	ne 5 Residence 28d. Describe how in		cify)					
al or Atte s after dea al Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hospital or Attending Physician or Attending Physician State death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)					
To t with To t	Σ	29b. Signature and title of certifier	29c. License number 0 0 60 3 36	10	Date signed (Montil						
10		30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 2. Registrar's Signature	Print) 1126 apal	ct or	19 21	740					
Sta Registr	_	OCT 3 0 2009	nes	,							

09-08345								
Jason Mark Allen								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		, maryiania	Cer	tifica	te of	Death	a mon	tor rigg	Re	g. No.	20	109	31	499	
Physicia ledical Examin	n/	Decedent's Name (First, I	Middle,Last) Mark	Aller							Date of Death Month October 27		Year		Time of Dea 2200 hrs	th	
**		4a. Facility Name (if not inst					41	o. City, Town, or	Location o		October 2		ounty of De				
		Upper Chesapeak	e Medical	Center			Bel Air Harford										
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. Ia	st birtho	ay)	If Under 1 Yea		_	8. Date of Birt	h(MM/DD/		Birthpla	ace (State or	r	
Director		217-98-4623 1 Months Days Hours Min.							Min.	11/10	/198]		Countr	y) MD			
>-		Usual Residence of Decede			an												
w any		10a. State 10b. Cou	inty		10c. City,	Town or	Locatio								d. Inside City		
faryland 28a-f show Lat once.	ģ		ne Ar	undel					evern							XINO	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	0 01				ŀ	10f. Zip Code			10	og. Citizen	of What (Country's	?		
ith the 23a c	ם	1644 Shannon			E	o T.	2.14	December 1	2114			1		SA			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ner		Married	2. Was Decedent Armed Forces?		S.		Decedent of His s, specify Cuba				14.	White, et		Indian, Blac	:к,	
ter de	리	3 Widowed 4	Divorced If	Yes, Give Year	X No		1	Yes 2 X No	specify:			Spe	ecify:	Whit	- 0		
urs af Itural	함	15. Decedent's Education	ه ا	r Dates:	npleted)		cedent	s Usual Occupa	tion (Give I				of Busine				
72 ho	Completed	Elementary/Secondary (0	12)	College (1-4 or	5+)	du	ring mo	st of working life	. DO NOT	use retired	1)						
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 's event, the Medical	립	12		2			C	Carpente	er		Const			truc	tion		
5-0 iled v Hygi I othe		17. Father's Name (First, Mi							18.Mother	's Name (F	irst, Middle, N	/laiden Sur	name)				
121 d be f fental sarked	Be	Steven M		len		1.00			Ke]	4	J.	Cur	4				
MD 2 d 2 shoul tth and M n 27 is m	ပ္	19a. Informant's Name/Rela Kelly Jo Far		e, Print) (mother	٠,	4		Address (Stree									
and 2 ealth cen 2 em 2	1	20a. Method of Disposition	are	(motnet				nion Ch			, Chest	20c.Loc	Wn , I	4D 2	vn State		
Ore	- 1	1 X Burial 2 Crem	ation 3	Removal from St	ate c	remator	y or othe	er place)	,,	Nov.				,			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medium	1	4 Donation 5 Other 21. Signature of Funeral Ser			Ct	ırry		etery		20					. Virg		
Bal permi Depa Impo injur		21. Signature of Pulleral Ser	VIE CHEIR)				me and Addres			alling					Α.	
Physician	\dashv	23a. Part I. Enter the disease	e, or o plica	tions that caused	the death.	Do not								_	L Z Z Approximate	Interval	
/Medical	-	failure. List only one ca		^{line.} Methado	ne ir	ntox	icat	ion						E	Between On: Death		
xaminer		Immediate Cause (Final disc or condition resulting in dea		e to (or as a cons										\rightarrow			
		Sequentially list conditions,	b														
	<u>.</u>	if any, leading to immediate cause. Enter Underlying Ca	use	e to (or as a cons	equence of):											
<u></u>	Examiner	(Disease or injury that initiat events resulting in death) L		e to (or as a conse	equence of):								+			
= 5 4			d					<u> </u>						\perp			
'60, cate be ex physician he burial	Medical	X UNPENDED		AMENDED 23a,2	7,28	ı-f,	perm	nE, g898	12/1	10/09	TT						
	AMENDED AMENDED 23a,27,28a-f,permE, g898 12/10/09 TT IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day								V	oor							
30x 687 death certific	/sician/	past 12 months?		Live birth Pregnant at	time of dea	2 th 5	=	al death 3 er (Specify)		c pregnanc	у	IVIC	Month Day Year				
Box e death o the atten	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause																
the contract of the contract	by P	Part II. Other significant co	nditions co	ontributing to deat	h but not re	sulting i	n the un	derlying cause	given in Pa	art I.					cause of de		
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cords,	Completed										24a. Was a autop	sy	prior	to com	sy findings a pletion of ca		
Rec The la	틹										perfor 1 Yes		deat 1 √	h? Yes	2	No	
of Vital Records, ng Physician: The law requir offer this certificate has been s' meral director, page 2 should the	Be	25. Was case referred to me examiner?						26.Place		(Check onl	y one)						
n of Vital ding Physician: After this certif funeral director,	의	1 ✓ Yes 2 No	Hos		ent 2 🗸				Other ₄	Nursing i		Residence		ther:			
n of		27. Manner of Death 1 Natural 5		28a. Date of Inju (Month, Day,Y	iry ear)	28b. Tir	ne of Inj		ıryat Work Yes 2 X	. i	3d. Describe f ink	now injury	occurred				
Sio Atten r death ector: by the	듛	2 Accident	Pending nvestigation	Fd 10/2				am				N		- D	D	0::	
Division tal or Attendii rs after death.	Certification:		Could not be letermined	28e. Place of In					ounding, et		or Town, S	tate)500	Upp	er (Chesap	er, City eake	
		29a. Certifier		: To the best of m		_			ata and nic			Air,		ototo d			
the F thin 2 the F	Medical	,	Examiner: 0	n the basis of exa											ause(s)		
To COT	ĕŀ	29b. Signature and title of ce		od manner stated.	71	00	11	29c. Licens	se number			29d. Dat	e signed	(Month,	Day, Year)		
		Hiela?	1.11	1/00	11	200	56	O.C.	M.E.			Octob	er 28, 2	009			
	ŀ	30. Name and address of pe	son who con	npleted cause of d	eath (Item	23a)											
		Victor Weedn MD	JD Assi	stant Medical	Examin	er 1	11 Pe	enn Street, E	Baltimore	e, MD 21	1201						
Sta	-	31. Date filed (Month, Day, Yo	ear)	32 Registra	r's Signatu	e	<i>i</i> —										
Registr		MOVUS	ZUUS	Leven	J.	19	C. Al										
DHMH 17 Rev 1/200 OCME 2006)1		UUIVIE		~	ÖŔIC	SINAL										

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 20a-c & 22, per FH G897 11/12/09 TT State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - State Registrar			Certifica	ate of	Death		Reg. N	2009	34996
/N	Physici	22	1. Decedent's Name (First, Middle	, Last)						e of Death nth D	ay Year	3. Time of Death
	Physici /Medio		Naomi Anderson	2					10		5 2009	1:20 P. M.
	Examin	er	4a. Facility Name (If not institution,	47		4b. Cit	ty, Town, o	r Location of De	eath	1	c. County of Death	
" مرد		щ	FRANKLIN SQUA	4 -1			OSEL		In I		BALTIMO	
	Funeral Director		801-36-8887	6. Sex 7. Age	(In yrs. last birthd	Month	ler 1 Year s Days	If Under 24 H Hours N	lin. (Mo	e of Birth onth, Day, Year 26, 1	950 Virg	
	and		Usual Residence of Decedent 10a. State 10b. County	T	10c. City, Town or	r Location					1	0d. Inside City Limits
a-f sho	e Maryl. ta-f sho	ctor	MD Balts	imore :	Parkville							1 □ Yes 2\$ No
	th with th	Funeral Director	10e. Street and Number 8710 Emge Road				Zip Code 234			10g. C	Citizen of What Cour SA	itry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. there is no steen a same or 28a-f show ent, the invited Everylland and son and the same of the same	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than. Important: if item 27 is marked other than. Important: if item 28 as a series of the properties of the marked other than a series of the marked other than a series of the marked other than a series of the marked once.	5	11. Marital Status 1 ¹ Never Married 2☐ Marrie 3☐ Widowed 4☐ Divorced	12. Was Decedent E Armed Forces? ed 1 □ Yes 2 □ N If Yes, Give Year or Dates:	ver in U.S.	it Yes, sp	cedent of Hoecify Cuba 2½ No	lispanic Origin? an, Mexican, Pu Specify:	? (Specify Ye uerto Rican,	s or No- etc.)	14. Race - Americ Black, White, Specify: bl a	etc.
21215-0036	thin 72 h e. an "nat t	Completed	15. Decedent' (Specify only highes: Elementary/Secondary (0-12)	's Education t grade completed) College (1-4or 5-	+) (G		vork done use retired	eation during most of t d)	working	16b.	Kind of Business/Ind	Justry
7	ed with	5	10	0	ho	usewif	Ee				n home	
altimore, Maryland	should be file and Mental H marked oth umatic even	To Be	17. Father's Name (First, Middle, L Cecil James And	,					Name <i>(First,</i> rie Ja	Middle, Maide ames	n Surname)	
ar)	2 short and I is mainairauma	. 7	19a. Informant's Name/Relationsh		19b. M	ailing Addre	ss (Street	and Number or	r Rural Route	Number, City	or Town, State, Zip	Code)
≥,	and and marking markin	13	Elwood Anderson	/brother				<u> </u>				and 21218
more	Pages 1 ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from State	20b. Place of Di	-		i i	Date		Location - City or To	
<u>=</u>	partm porta porta y inju		21. Signatur of Funeral Sovice L		tor	22. Name	and Addre	ss of Facilit CA	TA/St	ephen "I	tsville, ohrman 8.	7]7 Green
m	De la la la la la la la la la la la la la		1 Mm	1/1/1/44/1/		Baltin	nore.	Marvia	nd - 212	01 2128	6 Green 1	Pastures Dr
	hysician /Medical		23a. Part1. Enter the disease, or o shock or beart failure. List of immediate Cause (Final disease or condition resulting in death)	a. METAS	the death. Do not e.	enter the m	ode of dyir	ng, such as care	diac or respi	ratory arrest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or de a	s consequence of):							
, 00,	certificate be executed right of the burial and see as the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):	··· <u> </u>						
68760	cate t physic the b	Medical	'	d								
O. Box 6	he death certific the attending p thed for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 ∐ Fetal death	3 Ectopic		у			23d. Date of delive	ery Day Year
ds, P.	w requires that the de s been signed by the s should be detached t	by	Part II. Other significant condition	ns contributing to death bu	t not resulting in th	e underlying	g cause giv	en in Part I.	23		use contribute to the	
Records,	g 2 0	Completed							-	a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
		a i	25. Was case referred to medical					26. Place of I		Yes 2.	lo 1 ☐ Yes	2 No
	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	nt 2 ☐ ER/Outpa	atient 3 🗌 I	DOA Oth	or:			6 ☐ Other (Specif	
on o	ding h. Afte fune	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		y 28b. Tim (Year) Inju	e of ry M	28c. Injur Worl			escribe how inj		<u></u>
Divis	of or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ot be ned 28e. Place of Inju- building, etc	ry - At home, farm, . (Specify)	street, facto	ory, office		28f. Loc Cit	cation (Street a y or Town, Sta	and Number or Rura te)	ıl Route Number,
:	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) Certifying 2 Medical E	g Physician: To the best of Examiner: On the basis of and manner stat	examination and/o	eath occurre or investigati	ed at the til on, in my c	me, date and p ppinion, death o	lace, and du occurred at th	e to the cause ne time, date a	(s) and manner as s nd place, and due to	stated. the cause(s)
1	To the within To the Comple	Me	29b. Signature and title of certifier			2	29c. Licens	e number		29d. D	ate signed (Month,	Day, Year)
			cago	3 > 111	0	4	DO	062	176	000	to1-2-7	5 2009
			30. Name and address of person w	vho completed cause of de	eath (Item 23a) (Ty	pe, Print)			- 1 4		- NOW Z	
			Chienyenwa	Nysach.	nemere	MD.	9000	FRANKL	in So	UARE D	RIVE BALI	5, 2009 TO, MD 21237
	Sta Registr	te ar	31. Date filed (Month Day, Year)	9 Server 32. Registra	r's agnature	Kal						,

ANDERSON, NAOMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 4:15 рм Areletha A. Burgess 2009 Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris <u>Towson</u> Balto Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Country) Director N.C. 213-20-8192 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits N/A MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6210 McClean Blvd 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 XNo Specify: Black 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) unk Elementary/Seconday (0-12) College (1-4 or 5+) Register 9th grade N/A Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Orah Harris Dicy Tabron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Burgess-Son 6210 McClean Blvd Balto, Md 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Foret 11-6-2009 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March East lan wa 1101 Ε. North Avenue Balto MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) REBRO Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes No Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 1 Inpatient 2 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of injury Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tit 29d. Date signed (Minth, Day, Year) eted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

09-08086	
Frank Battagilia, J	r.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

•	Re	For State Certificate of Death		Reg.		19 3499					
Physiciar ledical Examin	ı/ 1. er	Decedent's Name (First, Middle,Last) Frank Joseph Battaglia, Jr.		Date of Death Month D October 17,	2009 Year	3. Time of Death 2239 hrs					
	48	a. Facility Name (if not institution, give street and number) 4b. City, Tow Upper Chesapeake Medical Center Belair	n, or Location of Death		4c. County of Death Harford						
Funeral Director	2	213-32-8079 1XM 2F 73 Yrs.		1	Cou	place (State or Foreign ntry) Maryland					
any	_	sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
A	ا ه	Md. Balto. Kingsville	9			1 Yes 2 XNo					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygione. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	De. Street and Number 10f. Zip Co		10g	. Citizen of What Coun	try?					
with the			of Hispanic Origin? (Spe		USA 14. Race - Americ	an Indian, Black,					
r death	?∣	Never Married 2 Married 1 X Yes 2 No	Cuban, Mexican, Puerto R	tican, etc.)	White, etc.						
irs after tural", iminer	⋧┝	3 X Widowed 4 Divorced of Yes, Give Year 1958-1962 1 Yes 2 X 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oc	cupation (Give kind of wo		Specify: Wh	ite					
6 n 72 hou an "nat ical Exa		Elementary/Secondary (0-12) College (1-4 or 5+) during most of working	ng life. DO NOT use retire	(bd)							
5-0036 led within 72 Hygiene. other than the Mydical	Completed	8th Crew Sup 7. Father's Name (First, Middle, Last)	Dervisor 18.Mother's Name (First, Middle, Ma	City of B	altimore					
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the MA	Re	Frank J. Battaglia.Sr.		Mae Hi		7.0.1					
MD 21 d 2 should Ith and Mer n 27 is man	이	9a. Informant's Name/Relationship (Type, Print)	(Street and Number or Ru								
re, MD 2		0a. Method of Disposition 20b. Place of Disposition (Name	of cemetery,	Date	20c. Location - City or	Town, State					
altimore, rmit. Pages 1 a spartment of He iportant: If ite	4	4 Donation 5 Other Specify: St. Joseph Cen	metery 10-2	22-2009	Fullerton,	Md.					
Baltil permit Departm Importa	2		^{ddress of Facility} Schi Belair Rd.								
Physician	it, shock, or heart	Approximate Interval Between Onset and									
/Medical- vaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) To condition resulting in death) To condition resulting in death)	tic cardiov	ascular	disease	Death					
	l _s	Sequentially list conditions, They had not be immediat. Due to (or as a consequence or): Due to (or as a consequence or):									
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ted I lusit	Exar	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
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8760, ificate be en appropriate by the burial street burial controls.		FEMALE: 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregnar	ncy	23d. Date of delivery	/ Day Year					
Box 68 to death certificate attending ed for use as t	siciar	past 12 months? 4 Pregnant at time of death 5 Other (Specific		- 1							
D. Bc	2L	Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not result	pacco use contribute to	the cause of death?							
ires that the signed by	Seigure disorder										
ords, aw requir as been s	ompleted			24a. Was ar autops perforn	y prior to	topsy findings available completion of cause of					
of Vital Records, ag Physician: The law require ther this certificate has been so meral director, page 2 should	ပ⊢		Dinne of Death (Chart)	1 ✓ Yes 2		es 2 No					
Vital Rec	9 2 0	55. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DO	Other Nursing		Residence 6 Othe	r:					
ing Phy After th	- -2	77. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Dey, Year) 28b. Time of Injury 28		28d. Describe ho	ow injury occurred						
Division falor Attendir s after death. al Director: A led in by the fu	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, c	1 Yes 2 No office building, etc.	28f. Location (St	treet and Number or Ru	ural Route Number, City					
Divi	ertit	Suicide 6 Could not be determined (Specify)		or Town, Sta							
/ 84 5 2	O 2	Pa. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tion 2	ime, date and place, and opinion, death occurred at	due to the cause t the time, date a	e(s) and manner as stated	red. ne cause(s)					
To To To To To To To To To To To To To T	8 _	and manner stated.	License number		29d. Date signed (Mo						
		Carol Hallan	O.C.M.E.		October 18, 200	9					
8/1	3	10. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, B	altimore. MD 2120	1							
Sta	ite ³	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
Registr	ar	MAY 0 2 2009 James G. parks									

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G898, 12,4409, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34999 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10-26-2009 1216 P M Michael W. Billings 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 215-28-9040 8. Date of Birth (Month, Day, Year) 01-01-1927 6. Sex 7. Age (In yrs. last birthday) Days 1**∑** M 2□ F 82 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2X No MD Harford Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 818 Petem Rd 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Purchasing Manager Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Billing Martha Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine Billings (Wife) 818 Petem Rd Kingsville, MD 21087 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Bavview Crematory 10-29-2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio my opula Due to (or as a consequing e :: Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last obssity morbid Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Funeral

Director

'natural", or items 23a or 28a-f show dical Examiner must be notified at

27 Is marked other

Physician

/Medical

Pages 1

Director

Funeral

2

Completed

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Physician/Medical

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Completed

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Certification: To

Medical

31. Date filed (Month, Day,

death with the Maryland

Baltimore, Maryland 21215-0036

12 V State

Registrar

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Brannon Braggs State of Maryland / Department of Health and Mental Hygiene 2009 35000 1- For State Certificate of Death Reg. No. Registrar 2. Oate of Oeath 1. Decedent's Name (First, Middle,Last) Physician/ Month Oay October 27, 2009 1040 hrs Medical Examiner BRANNON BRAGGS 4a. Facility Name (if not institution, give street and number) 4c. County of Oeath 4b. City, Town, or Location of Oeath 5804 Morningbird Lane Columbia Howard If Under 1 Year If Under 24Hrs. 8, Oate of Birth(MM/QQ/YYYY) 9, Birthplace (State or 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Davs Min Director 452-25-4435 Country) Yrs 1 **Y**M 2 F 09-17-1970 Usual Residence of Oeceden 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No DALLAS **TEXAS** Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 75227 7030 LONDON FOG DR. Funeral 12. Was Oecedent Ever in U.S 13. Was Oecedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces? White, etc. 1 X Never Married 2 Married must Yes 2 X No Specify: BLACK Widowed Oivorced s, Give Yea Yes 2X No specify: Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. 4 2 16a. Oecedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **NEVER WORKED** 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WILLIAM LLOYD FOMBY Be BEVERLY ANN BRAGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERMITA PULLEN/DISTER Sister 7030 LONDON FOG DR., DALLAS, TX 73227 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/07/09 **CARVER** FERRIS. TX 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD mes 23a, Part / Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and fallure. List only one cause on each line /Medical Death Citalogram intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions Oue to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical x AMENDED 19a,b per fh g897 11-2-09 vt 23a,27,28a-f,perME, g897 11/6/09 TT X UNPENDED attending physician for use as the burial Box 68760. IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Oay Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown 9 Unknown 23e. Oid tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available peen page 2 should 24a Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 V Yes 2 No 26.Place of Oeath (Check only one) the Hospital or A tending Physician: 25. Was case referred to medical of Vital director æ examiner? Other; DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 V Yes ٩ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27 Manner of Death 28b Time of Injury 28c. Injury at Work? 1 Natural Yes 2X No Division unk 5 Pending within 24 hours after death To the Funeral Director: Fd 10/27/09 Fd 10:20 2 Investigation Accident in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5804 Morningbird Ln. Columbia, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide (Specify) found in a house 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME October 28, 2009 nd address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Oate filed (Month, Day, Year) State

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